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AIDS EDUCATION OF SCHOOL-AGED YOUTH

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BEFORE THE

COMMITTEE ON GOVERNMENTAL AFFAIRS UNITED STATES SENATE

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AIDS EDUCATION OF SCHOOL-AGED YOUTH

THURSDAY, MAY 3, 1990

U.S. SENATE,
COMMITTEE ON GOVERNMENTAL AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 9:35 a.m., in room SD–342, Dirksen Senate Office Building, Hon. John Glenn, Chairman of the Committee, presiding.

Present: Senators Glenn, Kohl, and Heinz.

OPENING STATEMENT OF CHAIRMAN GLENN

Chairman GLENN. The Committee will come to order.

Today's hearing is about children and teenagers who, in the words of one of our witnesses, are lovable, capable and of infinite worth. None of us would quarrel with that one, certainly. However, it is simply not good enough that we adults know this about our children. It is essential that every young person believe this about himself and channel that self-esteem to eliminate or reduce the risk of becoming infected with the human immunodeficiency virus (HIV), which causes AIDS.

Now, that is no easy task. As they grow up in the world today, young persons face increasing pressure to engage in high-risk behavior such as IV drug use and sexual activity. Too often, family constraints, guidance, and counseling are missing or just not there. Tragically, too many youths have no idea where their next meal or bed is coming from. It is not surprising that those realities tend to skew a young person's ability to evaluate the threat of death from AIDS 5 to 10 years down the road.

The Centers for Disease Control (CDC) is the lead Federal agency responsible for educating our school-aged youth about the dangers of AIDS and ways to avoid HIV infection. While CDC grants for such education have grown from $7 million in 1987 to over $40 million in 1990, information about the resulting programs—what is working and what is not working—has been limited. As a result, the Governmental Affairs Committee requested that GAO evaluate CDC's efforts, and GAO has prepared its findings and recommendations in two reports, which we are releasing today. I believe those are probably copies of the two reports back there on the table that are available now.

The GAO's first report is based on its nationwide survey of school districts and their policies toward reaching kids who stay in school, and training teachers to teach about this very sensitive subject. The GAO found that for this nationwide problem, more Federal leadership is needed to improve not only HIV curriculum, but

also teacher training and information about students' knowledge, behavior and beliefs.

The second GAO report concerns the slow progress by the Federal, State and local governments to reach the small but critical percentage of youth who are not in school. This group includes the runaways, the homeless, the incarcerated, the migrants, and street youth who may be involved in a variety of high-risk behaviors such as IV drug use and prostitution.

As much as people may want to get AIDS behind them, get rid of it, thus get the problem solved and go on, the epidemic among youth may be only just beginning. According to CDC, there are 500 reported cases of AIDS among teenagers. Now, that does not sound like much, does it? Five hundred cases of AIDS among teenagers. And that figure is small when compared with the over 100,000 AIDS cases overall, but it is no comfort to the health experts who know it is possible to be infected with the human immunodeficiency virus and not show any symptoms of the disease for 10 years or more. So, that figure of 500 confirmed AIDS cases now among teenagers undoubtedly translates into many, many, many times that number who now have the virus that will progress to AIDS as the teens go into their twenties. In fact, health experts see that 20 percent of those people diagnosed with AIDS in this country are between the ages of 20 and 29.

And there are abundant signs that the virus is spreading. Some doctors report that they now have a dozen infected teenage patients, while only a year ago they had one or none. Studies indicate that as many as 1 percent of teenagers in cities like New York and Miami, where the virus is prevalent, are already infected—1 percent, 1 out of every 100 kids you would run into would have the HIV virus now in some of those areas. That translates into an enormous and expensive medical problem for our Nation until a cure and a preventive vaccine can be developed.

In the meantime, the battle against the disease can only be won if our children are taught how to fight against further infection. Indeed, the Presidential Commission on the HIV Epidemic has stated. "The term 'AIDS' is obsolete. 'HIV' infection more correctly defines the problem . . . Continued focus on the label 'AIDS' contributes to the lack of understanding of the importance of HIV infection as the more significant element for taking control of the epidemic." Since education is still the most potent weapon we have to control this epidemic, we need education programs that provide the facts about this disease. We need education programs that promote safe behaviors.

Most of all, we need education programs that work, and today that is what we are trying to explore, what is working and what is not, and how do we know.

Now, I want to do something a little unusual this morning. I do not usually do this, but I am going to read from the report. I know the report is available and the press people and all the rest of you can read it as well as I can, so there is no need to read it. But I was rereading some of it this morning, and it was so shocking that I think it is worthwhile to read this into the record and draw special emphasis to it, so we realize what the risk is and what the situa-

tion is with regard to trying to control the spread of this HIV virus among our young people.

Let me just quote in part from this and, for those of you who have copies of it, it is on page 10 of the report on school programs. Starting out at the bottom:

Yet the myth that there is no need to educate heterosexuals because the disease is not spreading beyond homosexual or drug-using people persists, the Citizens commission says. This belief hinders adequate education efforts.

Many teenagers engage in sexual behavior, such as unprotected intercourse or intercourse with two or more partners, that can transmit HIV. Data show that:

1. Youth have sex at an early age—the average age of first intercourse is 16. The Office of Technology Assessment reports that 78 percent of males and 63 percent of females have sex while teenagers.

2. For many adolescents, sexual activity is frequent or often with more than one partners. Among unmarried females 15 to 19 years old, about 40 percent reported having sex once a week or more, and 51 percent reported having two or more partners.

This is the age group 15 to 19 we are talking about.

An official of a national organization serving youth said that adolescents interpret a "long-term monogamous relationship" to be one with their current lover that lasts for several months.

3. Much of teenagers' sexual intercourse occurs without the protection of condoms. Although estimates vary, studies we reviewed found that only about one-quarter of sexually active adolescents used condoms. Serial monogamy in combination with the reluctance to use condoms with one's monogamous lover exposes youth to the risks associated with unprotected intercourse with multiple partners.

Homosexual youth, particularly males, are of special concern as they have been one of the high-risk groups for HIV transmission in the United States. As youth, these teens also search for their identity and struggle to establish satisfying relationships, leading them, in some cases, to experiment with heterosexual affiliations. This places lesbian youth, who generally would be in a low-risk category, at heightened risk of infection. Such exploration also serves as a possible link between homosexual and heterosexual youth in the transmission of HIV.

Thus, many teenagers are at risk of HIV infection through sexual contact. The gravity of the situation is indicated by the fact that young people have the highest incidence of sexually transmitted disease (STD)—as it is called—in comparison with other age categories.

Listen to this:

Nearly one-half of the 20 million STD patients are under age 25. About 2.5 million teenagers contract a sexually transmitted disease annually. The incidence of STD among minority youth is generally far higher than among their white counterparts.

Women who become pregnant through unprotected sexual activities place not only themselves, but also their unborn children, at risk of HIV infection, as the virus can be transmitted perinatally. Ten percent of teenage women become pregnant every year, and 40 percent of U.S. teens will become pregnant at least once before age 20, the Guttmacher Institute reports. There are 1 million teen pregnancies each year.

I guess the answer to that is you do not just say "don't," because that is not going to work. But I found those figures really shocking. As I say, I think I am pretty well up on things and keep in touch with the kids and all, but that kind of stuff shocks me and there just is no way around it. We have a bit of a problem, it is a national problem and it is one we are trying to address here today.

I do not want to go on. We are here to hear our witnesses, not me today, but I found that shocking enough that I thought it was good to draw special emphasis to it this morning.

One of our Committee members who has repeatedly expressed a very, very major interest in issues related to kids and our young

people and how we can improve their lot and do things here at the Federal level where we address problems that are national is Senator Kohl. He has been active in looking into these different areas and supporting our efforts in that area. He has another hearing this morning he has to go to and preside over, at 11 o'clock, so he could not preside over the whole hearing this morning. But he will be taking the lead in some of these areas and I am particularly grateful for his help and for the wonderful work that he is doing in this area. I am glad he can be here at least for the first hour or so of the hearing this morning, and he will be taking the lead in a lot of these areas for the committee in the future.

Senator Kohl.

OPENING STATEMENT OF SENATOR KOHL

Senator KOHL. Thank you very much, Mr. Chairman.

There is no question among experts that AIDS is the most dire public health crisis facing our country today. Over 120,000 Americans have already been diagnosed with the disease and, of these, over 70,000 have died.

It is estimated that more than 1 million people in our country are HIV infected. There are very many who are not learning about AIDS. They are not being taught to avoid the behavior that leads to HIV infection, nor are they learning how to deal compassionately with persons with AIDS. Without adequate education, two things happen: Kids continue to believe they are immune from this disease and misunderstanding and prejudice are allowed to fester.

The GAO reports that one-third of America's schools are not providing AIDS education. The GAO also reports that many of the schools that do provide AIDS education are not doing enough. Many students only learn about AIDS once in the 7th or 8th grade, when they are low risk of infection.

In my own State of Wisconsin, the only money being spent on in-school education is $246,000 of Federal money allocated by the CDC. This effort is grossly under-funded. Recent legislation passed by the State Legislature would have required students to take at least two comprehensive AIDS education programs, but this legislation was vetoed. The rationale was lack of funds, not the expense to society caused by an increasing number of kids coming down with AIDS.

As tough as it is to get the message to kids in the classroom, it is infinitely more difficult to reach kids on the street and they are at incredible risk. A report released just 2 weeks ago by the Wisconsin Division of Health stated that 1 in 500 Wisconsin residents became infected with the HIV virus in the 1980's. In the next decade, between 9,300 and 14,000 more will become infected. Kids on the street are easy targets for both the pusher and the pimp, and if we cannot find a way to reach out to these young people, we will be writing a lot of death sentences.

Part of what we hope to learn here today is what is being done right. It seems important that, if we are going to stem the spread of this disease in both high school and out-of-school populations, we need a sense of what is happening in those kids' lives and what

their needs are, then we have to match our resources with these needs.

One of the things that strikes me is how different it is to be a kid growing up in the 1990's. I did not have to worry about AIDS or drugs or street crime. I could just be a kid and have fun, and sooner or later start taking responsibility for a life full of hope and bright prospects. If I screwed up—which I want to assure the Chairman I never did—it was not a life or death sentence, it was just part of growing up and I could learn from my mistakes and move on. The stakes for that screw-up today are much higher.

With dangers like AIDS, ignorance kills. Getting the word out to today's young people is a special challenge and I hope some of our witnesses can shed some light on the best ways to face that challenge.

So, I thank the Chairman for his leadership on this critical issue and look forward to hearing from our witnesses.

Chairman GLENN. Thank you, Senator Kohl.

Senator Heinz, any comments?

OPENING STATEMENT OF SENATOR HEINZ

Senator HEINZ. Just briefly, Mr. Chairman.

First, It was my hope to spend a fair amount of time here this morning, but I have two other hearings, both starting at 10:00. I did want to come by to commend you for conducting this hearing, Mr. Chairman, on AIDS prevention and education, activities. And, I agree with Senator Kohl, on the need to be directed more than ever before at our young people. I think Senator Kohl was extremely eloquent about the costs of being wrong today.

Twenty or 30 years ago, if you made a mistake, the cost was not fatal. Today, life literally depends on avoiding mistakes. Outside of the research laboratory, education and counseling on HIV is our best line of defense to combat the growing AIDS HIV epidemic. I for one see absolutely no alternative to early intervention with education as a means of helping control the spread of HIV infection. I particularly want to commend and applaud the Centers for Disease Control for their efforts in this area.

I say that, because the Centers for Disease control has developed a range of HIV risk assessment prevention activities, including efforts targeted to school- and college-age youth. I hope, indeed I anticipate that today's hearing is going to illustrate that more must be done to strengthen HIV education and prevention outreach for our youth.

An effective cure for AIDS, in spite of newspaper articles that might lead you to conclude, is out of our immediate grasp. Notwithstanding the possibility at some future time of perhaps a vaccine, that is not where we are today, let alone any place close to a cure. As long as people do not delude themselves into believing there is some immediate magic technological, biological fix just over the horizon, then I think we should focus and will focus correctly on the prevention, education, and outreach that is necessary and a sound investment.

Mr. Chairman, I look forward to working with you, Senator Kohl, other members of this Committee, the administration, and

the CDC, to make sure that we improve insofar as we can and fully support our current endeavors and efforts to reach this very vulnerable segment of our population, namely, our younger people.

Thank you, Mr. Chairman.

Chairman GLENN. Thank you, Senator Heinz.

We will proceed. We do have quite a witness list this morning. I hope we have not overstepped ourselves in trying to do too much this morning with too many witnesses. I think we have eight or nine to appear and some of them have one or two people accompanying them, so we are going to have to move right along this morning.

Our first panel, Mr. Mark V. Nadel, Associate Director, National and Public Health Issues of GAO; accompanied by Ms. Teruni Rosengren, Evaluator-in-Charge of the Boston Regional Office of GAO; and Mr. Martin Landry, Evaluator-in-Charge of the Atlanta Regional Office of GAO.

Mr. Nadel, we look forward to your testimony. As I said earlier, in reading that GAO report this morning, I was rather shocked at what you have found just with regard to behavioral matters which indicates, even emphasizes how difficult it is going to be to deal with this whole thing.

We appreciate your testimony.

TESTIMONY OF MARK V. NADEL, ASSOCIATE DIRECTOR, NATIONAL AND PUBLIC HEALTH ISSUES, U.S. GENERAL ACCOUNTING OFFICE,[1] ACCOMPANIED BY TERUNI ROSENGREN, EVALUATOR-IN-CHARGE, BOSTON REGIONAL OFFICE, AND MARTIN LANDRY, EVALUATOR-IN-CHARGE, ATLANTA REGIONAL OFFICE

Mr. NADEL. Mr. Chairman and members of the Committee, I am pleased to be here today to discuss our review of education programs for youth designed to limit the spread of HIV infection. AIDS education generally refers to programs to provide young people with the knowledge and skill to avoid high-risk behavior leading to HIV infection.

We focused our work on programs sponsored by CDC. In 1990, CDC allocated $438 million of its fiscal year budget for all AIDS programs. As shown in the chart,[2] about half of these funds were used for prevention activities such as counseling and testing and health education and risk reduction. About 10 percent of CDC's overall AIDS funding was targeted specifically for youth education activities, which is the subject of my testimony today. These activities are generally run by State and local agencies which receive CDC funding.

I will be summarizing our findings very briefly, Mr. Chairman, because I know time is tight.

While American teenagers have received essential information on how to minimize the risk of becoming infected, we found that there still are gaps in the provision of AIDS education.

With regard to the programs for kids in school, I would like to make four points: First, while AIDS education is offered in two-

[1] See p. 47 for Mr. Nadel's prepared statement.
[2] See p. 51.

thirds of the Nation's school districts, smaller districts are much less likely to offer it. Second, AIDS education is usually not provided at the upper-grade levels where the need may be greatest. CDC has recommended that students at every grade level receive age-appropriate AIDS education. However, only 5 percent of school districts did so. Coverage has been most extensive in the middle grades, roughly grades 7 through 10, and much less so in the upper grades.

As our chart shows, only 15 percent of school districts provided AIDS education in the 11th and 12th grades. This is troublesome, because, as you pointed out earlier, sexual activity is likely to increase at these grade levels.

Third, essential data needed for planning and evaluation are inadequate. For programs to set priorities, evaluate success and improve operations, they must collect data based on students' HIV knowledge, beliefs and sexual and drug behaviors. However, over 80 percent of the recipients of CDC funds did not collect this information in an effective manner.

Finally, there is insufficient teacher training in most school districts. We have made a number of recommendations to the Secretary of Health and Human Services. Generally, we have recommended that CDC be required to provide more guidance and leadership to local education agencies for the provision of HIV education in the upper grades and in smaller school districts, to overcome barriers to the collection of essential information, and to develop guidelines for teacher training.

Now I would like to turn to the status of HIV education for out-of-school youth who, as you pointed out, are at higher risk because of their sexual and drug use behaviors. Providing AIDS education to this population is especially difficult, because they are hard to reach and resistant to prevention messages.

CDC's Division of Adolescent and School Health, which I shall refer to as DASH, has the lead responsibility for out-of-school youth, as well as for in-school youth, but we found that DASH has been slow to address the AIDS education needs of the out-of-school population.

State and local education agencies who are the primary recipients of DASH funding are not geared to serving out-of-school youth. Because they lack experience with out-of-school youth and the organizations serving them, few of the education departments targeted them for any AIDS education services.

DASH also funded six national organizations whose programs included out-of-school youth, and these organizations received almost six percent of the division's funds for all youth AIDS education.

Because their efforts did not effectively serve out-of-school youth, DASH plans to fund six local health departments or other local agencies to serve as focal points. These designated agencies will coordinate comprehensive community services, including AIDS education in high incidence cities.

However, another center in CDC, the Center for Prevention Services, already funds similar prevention programs in the same agencies. We believe these programs potentially duplicate DASH's planned initiative to fund health departments to target out-of-school youth. Considering the urgent need to reach these high-risk

youth, we recommend that CDC consider concentrating its efforts where the system is already in place to reach this population, rather than waiting to develop a new initiative.

This concludes the summary of my statement, Mr. Chairman. I would be happy to answer any questions from the Committee.

Chairman GLENN. Fine. Thank you very much.

Why not the 11th and 12th grades? Why does education fall off there? There must be some reason for this. That is obviously one of the periods of highest risk. Why is there less attention given? Is the idea that if you get them in the 7th, 8th, 9th and 10th, grades you have set the patterns that will then follow later on? It just seems to be irrational not to concentrate in the two top years of high school, when I would think sexual activity is probably going to be the very highest.

Mr. NADEL. It seems to be a matter of curricular considerations, Mr. Chairman. AIDS education is usually provided in the context of health education courses and these health education courses are most usually given in the junior high and early high school years. When there is no more health education, there appears to be no more AIDS education.

Secondly, educators have told us that there is already a very crowded school curricular and they find it difficult to shoehorn AIDS education in beyond the context of health education courses.

Chairman GLENN. Well, I can appreciate that we have got a full curriculum, but we are going to have some full graveyards out there, too, if we do not do something about this, unless we can find a better solution to the problem than we have so far.

In the spring of 1988, CDC assisted 24 States who agreed to administer a survey of students' knowledge, behavior and beliefs. Of those 24 States, only four used the survey questions that developed baseline data about students' behaviors that may result in HIV infection. The other 20 States just used the questions going to students' knowledge and beliefs about HIV. How could we best break down this resistance to learning about students' sexual or drug use behaviors? Do you have any thoughts on that?

Mr. NADEL. I think the first thing we need to do is to more carefully identify what those behaviors are. We think we know what some of them are, reaction in some communities against the sensitive nature of surveys probing students' sexual behaviors, fear in some school districts about publicity showing a very high proportion of their students use drugs or engaging in sex, premarital sex, so there are those kinds of concerns and there may be others.

The first thing is to identify, and once you identify them, to try to break down those barriers. Some of the things that might be done are to go to those school districts which have been successful in having surveys which completely surveyed the KBB's and find out what they did right, how did they overcome potential community opposition. Another possibility is to try to allay the fears of school districts and schools who do not want publicity, as I said. Perhaps the data could be confidential and only aggregated for public consumption at the State level, so no district or school needs to feel that it is vulnerable to criticism by parents.

There are probably more ways and I think CDC could well address means to break down these barriers.

I should add, Mr. Chairman, that the barriers, of course, that the barriers are not only at the local school district. There has been considerable opposition here in Washington to attempts to have surveys which ask people about their sexual behaviors.

Chairman GLENN. Well, that is all very titillating. We all giggle when we discuss these issues. Too many people do. It is nice that we all sit around thinking that our sons and daughters are out there being nice pure sons and daughters, except the statistics, if these things are even half-way correct that I read into the record earlier, show what the kids are actually doing.

Mr. NADEL. That is correct, Mr. Chairman.

Chairman GLENN. I cannot change that and we cannot pass a law that changes that, and parents cannot really control that, so the next best thing is to try, it seems to me, to get the information so that at least we can address this, and I would hope that people would start cooperating. We just want to take a head-in-the-sand approach that we will not deal with this, because we do not want to think about our daughter getting pregnant, we do not want to think about our son being a father at the age of 15 or 16. So we just put our heads in the sand and say no, it will all go away somehow. Yet, while they are doing this and becoming fathers and mothers at an earlier age, that is enough of a problem in itself. They are going to kill themselves, too often, with the spread of AIDS and that is what we are trying to prevent.

We are going by the 5-minute rule this morning here. Senator Kohl.

Senator KOHL. Thank you, Mr. Chairman.

Mr. Nadel would you agree that, in many instances, the reason that schools are not providing AIDS education or providing only to the 7th and 8th graders, it is because of some general discomfort from a political perspective with the whole issue of sex education? And to the extent that these problems are real, what specific types of things should we be doing through cooperative agreements that can facilitate education at the local level?

Mr. NADEL. I would like Mr. Landry to address that, because I know he has given this a lot of thought.

Mr. LANDRY. Yes, Senator, I think there may be some areas of the country where there is more reluctance to deal with this issue than in others. I think one thing types of hearings like this help bring out is to impress upon people the importance of educating their children.

For example, some children may be from rural areas whose school systems may not think they need AIDS education. They need to think ahead that many of those children will be moving from rural areas to urban areas, where there is a much greater chance of getting the virus, and those children need to have the information and be aware of the risk factors that they will have to deal with in those more urban environments.

Senator KOHL. So, are you saying there is a level of discomfort with the discussion of AIDS and sex at the school level?

Mr. LANDRY. Yes, Senator, very much so, there is in some locations.

Mr. NADEL. We also found, Senator, we reported on the results of the Guttmacher survey of what is actually taught, that the more

sensitive and explicit the topic, as one might expect, the less coverage there is in the classroom. There might be, you know, general discussions of the use of condoms, but once you get to more specific issues regarding the use of condoms, both classroom coverage as well as teacher training tends to drop off, so we think that is due to the sensitivity of the subjects.

Senator KOHL. All right. On the issue of data and research on the kids' knowledge, behaviors and beliefs, on the one hand, we say we have a crisis, an epidemic, so we need to respond to that immediately. On the other hand, we seem to be saying also that, in order to make most effective use of our limited resources, we have to get better information on the kids. So, how do we balance these two things? And how many variations of the message really are there? Can we not design a model curriculum that touches all the bases and is still targeted to those kids in an appropriate fashion?

Mr. NADEL. Senator, that is why we called for some greater efforts for CDC to exert more Federal leadership. It may be that there is a model curriculum. CDC has given guidance on generally the kinds of subjects to be covered and also has given guidance on the kind of survey that should be used, but perhaps there needs to be more emphasis on the fact that school districts do not have to reinvent the wheel and perhaps there should be more of a push for a model curriculum.

I know there is some resistance to Washington prescribing what the States should teach, but given the urgency of this problem, perhaps people could put those kinds of considerations aside for the moment and work together to see whether a single model curriculum is the way to go.

Senator KOHL. Okay. Just one other brief question, to get back to my first original question. There are what, many, many school districts in this country that refuse or simply will not teach education on AIDS and AIDS prevention and AIDS spread, for political reasons, sensitivity reasons, whatever, head-in-the-sand reasons?

Mr. LANDRY. Senator, we found about 27 percent of the school districts in the country do not teach AIDS education in their formal curriculum. We do not know exactly the specific numbers of those who do not do it for the reasons you mentioned, although it is 27 percent of the nationwide school districts who do not provide that education. Primarily, those tend to be the smaller school districts in the country.

Senator KOHL. Yes, I understood that is the statistics, but would you surmise that the biggest reason is the political sensitivity reasons?

Mr. NADEL. I do not know that we have a basis for knowing specifically for what reasons.

Mr. LANDRY. I think there are three or four reasons, Senator. One, of course, what you have mentioned. Some school districts have low incidence of AIDS and they do not see the necessity for dealing with that issue. Others do not have resources, they may want to but they do not have the resources to implement those programs. Finally, as we mentioned earlier, the crowded curriculum just tend to squeeze AIDS education out as a priority matter. We just cannot categorize those in any more detail.

Senator KOHL. Thank you, Mr. Chairman.

Chairman GLENN. Thank you, Senator Kohl.

I think we go back to square one on this and I do not know whether this was in the scope of your investigation or not. I think it was. Are schools the answer, or do we need another approach? We talk about training and education as though automatically the schools are the place where we are going to solve this, if we are going to solve it. I wonder if we need to consider other approaches.

In your study did you talk directly to any of the kids who had changed their behavior and find out why they changed their behavior; was it because of a role model or something they saw on TV, or was it from a teacher in school that put forward something or showed them charts or pictures or gave them the statistics that made them realize they had better shape up and change their behavior or they are going to kill themselves?

Did you talk to any of the kids to find out what had worked and what had not, up to now, at least? We are 4 years into this program. It took a long while to get going, we know that, but we are 4 years into it and there should be at least the first glimmerings of some experience level with these programs. What is working, what is not, and why?

Mr. NADEL. The unfortunate answer is that we do not have a real good handle on what is working and why. NIMH and NIDA are doing a major study now of how to change behaviors, but that is an ongoing effort and I do not think they have any results. Our staff did visit some classrooms where AIDS education was going on, but as to whether we interviewed kids, let me defer to my colleagues.

Teruni?

Ms. ROSENGREN. Well, in addition to providing HIV education in the school system, you also have to provide the same education at the community level. There are lots of different approaches that can attract their attention. You can use music celebrities and film celebrities, you can use peer educators, you can use outreach workers. Those are other kinds of methods that can effectively reach these kids in school, as well as out of school youth.

Chairman GLENN. We will have some examples a little bit later when we have some of the students put on a demonstration of what they have used to get the attention of their peers. I do not know whether things like that are working or not. We will talk to them when they get here.

Mr. NADEL. Senator, one of the frustrations about the lack of generalizable surveys and the lack of surveys which actually ask about sexual behavior is that not having such surveys, you have much less idea of what does work, which is why we emphasize the importance of collecting this information.

Chairman GLENN. Were surveys of the young people themselves part of your study?

Mr. NADEL. No, it was not.

Chairman GLENN. It was not. Is that the fertile field we should look into and does GAO want to take that on as a different study? Well, we can approach that later on. I am getting ahead of myself.

Mr. NADEL. On that one, I think I would like to defer to NIMH and NIDA.

Chairman GLENN. And Mr. Bowsher. That is all I have right now. Thank you very much. We may want to get back to you with some additional questions from other members when we review the other testimony here today. We appreciate your work on this.

I thought that one page of one of the reports was particularly worth reading into the record because it defines what the actual behavioral patterns are right now in this regard. It is an enormous program and an enormous problem, and we look forward to working with you on this in the future.

Mr. NADEL. Thank you, Mr. Chairman.

Chairman GLENN. The second panel, Ms. Delores DuVall, Warren Easton High School teacher, of New Orleans Public School District, New Orleans, Louisiana; Mr. David Kamens, Peer Educator, Washington, D.C.; Ms. Wanda Wigfall-Williams, Center for Population Options, of Washington, D.C., and she will be introducing at some point Mr. Brian Bess, a peer educator that I referred to a moment ago, at Ballou High School in Washington, D.C., and Mr. Rahim Jones, another peer educator at Ballou High School.

Ms. DuVall, we welcome you this morning and appreciate your bringing the other people along with you this morning.

TESTIMONY OF DELORES K. DuVALL, TEACHER, WARREN EASTON HIGH SCHOOL, NEW ORLEANS PUBLIC SCHOOL DISTRICT, NEW ORLEANS, LA [1]

Ms. DuVALL. Well, I really did not, I just brought myself, but I am glad they are all here.

I am very delighted to be here, certainly, because I really do have a lot to say and I guess it is really nice that I can vocalize about a hundred words a minute, so I guess I will be able to impart a lot of information.

I do not really want to spend any time going over figures. I think everyone here is aware of the statistics. But what I would like to get down to and what I think is probably one of the most important areas is how do we reach our children, how do we make them believe the things that we are trying to impart to them.

One of the questions that you asked is what am I doing, am I getting this information across, is it working, and if it is not, why is it not. Well, I am really pleased to say I think, in my particular school district in Louisiana, in New Orleans, it is working. Maybe I am tooting my own horn, but I do believe in this program. I think probably that is one of the first points.

I must agree that I think more teacher education is needed in this area. It is really easy for us to sit in the classroom and have this data and get all the information that we need concerning AIDS and say, yes, this is what happens with HIV and this is how we should prevent this and this is how it is contacted and this is how it is passed on. But then if a teacher gets into a classroom and he or she is not comfortable telling the students this, the kids read this, they see that, "Ah, this is B.S., because its an adult telling it, but do they believe what they're saying." I think we have to make

[1] See p. 63 for Ms. DuVall's prepared statement.

them believers, we have to become actors and actresses and we have to make sure the point hits home.

I would like to think that I do that in my classes. Some of the methods I use—we gave a play last year, my students wrote this play, after having all of the instructions on AIDS and HIV, on prevention and all of the other aspects we talk about. They gave the play, wrote the script, and performed it in front of our entire school body. This way, we were reaching everyone. We touched all of the students from 9th grade to 12th grade.

Of course, as with GAO, they found that, in Louisiana, students are only allowed to take 2 years or only required to take 2 years of physical education, which is the area health is taught and that is usually in the 9th and 10th grades. Again coming back to what Mr. Kohl said, we lose the 11th and 12th graders. I do not know why we feel those students do not need this.

We also lose some of our students because we are giving them a choice now of taking ROTC, instead of health and physical education, so they may not get any teachings or training at all.

My program is to touch everyone in Warren Easton, everyone in our school and everyone in the city, and I think I do that fairly well. The play we put on touched on all aspects of premarital sex, it talked about STD's, it talked about unwanted pregnancies, and we performed this for all of our students. We have the video tape in our library, we also have other schools that borrow the tape. So, kind of coming in the backdoor, I am getting a lot of information out.

I hold poster contests once a year. The students draw some very graphic posters. I think part of what we have to understand is, we have got to get out of this "bible belt" kind of thinking. Religion is great and we love it, we love God, but how do we deal, how do we talk to these children? We have to be straight up-front, we have to be honest with them, and if a child draws a poster for me and he shows someone having sex, what can I say except, " is that how you see this?" "yes", this is what it is. I have to accept that but we can do this with taste, the students are giving a message and these posters have a message.

We have our poster contest, they put posters all over. After the posters are made and presented, and the best chosen, every classroom in our school puts one in their room. I flood our school with posters.

Speaking about information on AIDS, I have posters in Spanish, I have them in Vietnamese, I have had them made because our school body envelops that portion of our society. We have quite a multi-racial environment.

Besides that, we have put on puppet shows, where the students write their own scripts, make their puppets and act out their scripts. Then they go around to the classrooms to perform this. What I do is I put out a list, the teachers sign up, "yes, Ms. DuVall, come to our class on third period with your children to perform," and we have done this and we visit every classroom.

I am really proud to say that I think the students at Warren Easton are very knowledgeable. We have taken part in many of the surveys, in fact, every survey that comes around I insist that we take part in. My students are very willing to do this.

Of course, not only being on the Drug-Free Schools Committee in New Orleans and on the Writing Committee for AIDS in Louisiana, I think I have had quite an impact.

I think what we need to do, one of the——

Chairman GLENN. If I could interrupt for just a moment, you say you participate fully in the surveys. Have you seen, as a result of your activities, a change in activity and——

Ms. DUVALL. Yes.

Chairman GLENN [continuing]. And do you have any data to back up the effectiveness of it?

Ms. DUVALL. Not hard data, other than just verbally talking with my students and what I have observed. I can tell you that we have fewer pregnancies in my school. Fewer children seem to be contacting STD's and, believe me, I get the word. It seems any time a kid has a problem, they come to me, they come to Ms. DuVall and say, "Ms. DuVall, what am I going to do, this is what's happening to me, I've got these red bumps all over me, what can I do." You know, they come to me with these kinds of things. Students I do not even have in my classes, but they know what I am about and they know that I am very candid and I am very blunt and I am very frank and I am not phoney—and I use scare tactics.

Maybe it is my old military training, but I believe if that is the only way we can get to them, scare the hell out of them, let me scare them, you know, make them believe what I am saying. That is—when you are dead, you are dead, if you contact AIDS, it is over. There is no cure, they know this, you had better believe it, do not put yourself outside saying this cannot happen to me—(famous last words), and we are all aware of that, I think.

I have students coming to me. I have even had them come to me and tell me when they have had their first sexual experience. You know, sometimes I feel like I want to punch them out, but I ask, "didn't you learn anything in my classes? What are you doing?

Now, we have a State law that is really kind of strange. First of all, they do not want us to even show contraceptives or condoms or anything like that. I do it anyhow. I may lose my job if they see this, but I do, because I think it is necessary. I show our kids, our young men, how to properly put on a condom. Surprising enough, some of them do not know. Teens feel "Oh, I know what this is about." How do they know what this is about? They think they know.

So, I think part of what our teachers have to do and I think some of the problems that we find, are so many of our teachers are not comfortable teaching this subject and are not teaching so it hits home, not teaching about behavior and how it is necessary that we must change how we act, how we behave, and what we do.

My students know that when they are in high school, they do more dating during those four years than they will do their entire lives. I tell them, you cannot go to bed every time you fall in love. You are going to fall in love 15 times in these 4 years and every time it is devastating. Students think; Oh, this is the last time, this is it for me, and then 2 months later it is all over and they're are in love all over again.

Look on their books and what do you see? They draw the little hearts and the hearts say "Dolores DuVall" and my boyfriend's

name is Henry—Mrs. Henry, Ms. Henry Brown, Mrs. H.J. Brown—all kinds of things that let us know how much in love we are. I show this to them, "look at your books," and they get really tickled when they see this, because they know I am telling them the truth.

We must have more teachers who are more willing to be candid, I think, to be up-front, to be stark about it. You know, we can spout out figures, we can give numbers, but let us face it, that becomes boring. We listen to it. That is not what we want it to be. We do not want to be boring, because that goes in one ear and out the other. We must hit home. We have to know that figures mean nothing to these kids.

In New Orleans, we have the French Quarter, we know we have a great many street children who are at high risk and who are in true danger, but thankfully we do have programs that are in operation to try to get a hold of these kids. I do not know how fully successful these are. I do not think they are as successful as they could be because I am almost at a point—I do not want to say that those students, those young people are lost to us, but they certainly are the hardest hit. They are the hardest ones to reach, because they have become so street wise. They think they know everything. You cannot tell them anything. "I know what this is, I am doing this because I have to live, I have to have food, I have to have a place to live, so I am going to—if it means selling a little sex, so what?" You see, they still do not think about the possibility of contracting AIDS.

How we are going to address that problem, I do not know. I think we need to go back to what we are doing in our homes. I think we have lost our family life and I think, above all else, that is the beginning. It is not family any more. We are all so busy into "my thing," that we no longer are into "our thing,"and I think that makes the difference.

We have kids who never see their mothers, single families who come home and kids raising themselves. The mother brings a boyfriend home for the weekend and he stays for the weekend. I try to make parents understand, they are sending out a message and that message is that it is all right to have sex without being married, you know, we have to understand that the marriage institution is still the basis of this Nation, and without it we do not have anything. We are going to have problems like this and the AIDS epidemic is going to get larger, it is going to get worse and we are going to lose more children.

As the GAO office said, which is very true, is that people who are contacting or who are showing AIDS now are people who have contacted the virus years ago. They did not know it. So, kids think that if it is not right here under my nose, it is not going to happen. They do not see down the road. They do not see that in another 5 years how devastating this could be.

There is a film that I show my kids called, and it was televised, called "Susie's Story," which I think gave a very excellent answer addressing this, about a young lady who got married after she had had an affair, prior to her marriage, then she falls in love, she gets married, she has a child and now she discovers she has AIDS and has passed it on to her son. How devastating this is.

Again, like I said, the numbers are astronomical. We teach a lot of children in New Orleans. I think that AIDS needs to be taught in the lower grades. Right now it is only taught in the 7th through 10th grade, that is our State law. We know for a fact that there are children below the 7th grade who are sexually active, either by choice or whether this has been put on them—we know that child abuse and the sexual abuse of youngsters is probably higher today than it has ever been—but we have children and you would be surprised to listen to the things they talk about, the things they think they know.

I think what we need to do is have more education at an earlier age, definitely, and I think somewhere along the line we had better start pushing the family. We had better start pushing what it is to have a mother and a father in the house, and we must also understand, as they say, the family that prays together stays together. You know, those things seem to be lost to us any more. Like I have said, we had better start doing "our thing," instead of just "my thing."

Thank you.

Chairman GLENN. Thank you, Ms. DuVall.

I think we will question as we go along with this panel.

Senator Kohl, do you want to lead off?

Senator KOHL. Thank you.

Ms. DuVall, first, obviously we need to commend you on the great job you are doing. I would like to ask you this question. In view of your success, what is it that others are not doing that they should do, other teachers are not doing that they should do to emulate what you are doing? Why are you more successful, in your judgment, than many others?

Ms. DUVALL. I think probably because, first of all, I really love what I am doing and I see the necessity and I am not uncomfortable teaching this. I am very comfortable with teaching sex education.

Of course, you know, in Louisiana, being one of the southern States—and I am not putting down any southern States, so do not throw shoes at me or anything—we do have this "we don't talk about these things," and so a lot of teachers, I think in the South, particularly those that were born and raised there, were brought up with that idea, we do not think about these things, subsequently, they are very uncomfortable teaching sex education. So, I think that we need more intensive teacher training, not only on just the facts, but how to impart this information. I think that we need more than those couple of hours of workshops that we have. It tells us nothing. We need teachers, we need to let them know that they have to begin to feel comfortable and be able to honestly say to a kid, "Hey, you can't go to bed with everybody you see, and if you do, if that is your problem, this is"—I almost sound like "Good Morning, Vietnam"—they need to learn how to share this information and bring it down to the point where the kids believe what we are saying, and not read it from a sheet.

Senator KOHL. How would you describe your level of commitment to what you are doing?

Ms. DuVALL. Absolutely total. I cannot say anything else, I do, because I think it is important. It is disgusting to see our children dying.

Senator KOHL. How would you describe your sense of urgency with respect to what you are doing?

Ms. DuVALL. It is most urgent. We are losing far too many of our students. We are not only losing them to diseases, but if they are not where we can put our hands on them, where we can give them something, then they are really lost. The child that is on the street, he is hard to get information to.

Senator KOHL. So, you are a person whom you would describe as totally committed to success in your job——

Ms. DuVALL. Oh, absolutely.

Senator KOHL. And you feel that it is a job of the greatest urgency.

Ms. DuVALL. Yes, I do. I could have had an administrative position, but never, I'm needed in the classroom.

Senator KOHL. You approach it in that kind of manner, obviously, and commit yourself to it.

Ms. DuVALL. Yes, I do.

Senator KOHL. It has a lot to do with your success?

Ms. DuVALL. Yes, it does. The students read this and they understand and they respond to that, yes, they do.

Senator KOHL. Thank you, Mr. Chairman.

Chairman GLENN. Thank you.

Ms. DuVall, are there other approaches besides school that may be part of a community program, or do you think the school is the most effective way of doing this? And you may be prejudiced because you are part of that particular system, but are there other things that can be done also?

Ms. DuVALL. Yes, I do think there are other things. In fact, I have done other things, such as, going to churches with information, with films, going to the pastor or the priest or whomever and saying, "Hey, may I come in one night when you're having one of your meetings, can I come in and can I show you this, can we talk about this." But there needs to be more of me to get into those communities.

We have so many communities in New Orleans that are so treacherous, and it seems not only New Orleans, but all over, where people are just afraid to go into these communities because of the crime rate, which is so very high. We have a hard time reaching those people. We have a hard time getting into those areas. Even if you get someone to say yes, I will let you use this building, you can come in and you can talk, what is the number of people that you get attending? Very small.

Chairman GLENN. What kind of feedback do you get from the parents of the students? Do they react favorably, generally? I can just hear some of the comments, when you are teaching the boys and showing them how to put condoms on.

Ms. DuVALL. Right.

Chairman GLENN. That is an incitement to go use them. I can just hear the comments from some people in the community. What reaction do you get from the parents?

Ms. DUVALL. Surprisingly, not that. I have found overwhelmingly with my school that my parents are in total agreement with what I am doing. They say to me, "Ms. DuVall, you were right, we need more teachers like you, yes, please. I don't know what I'm going to do with Johnny, I'm glad you're here to do it," and so they really do. I can honestly say I have had no negative feedback whatsoever.

Chairman GLENN. My name being what it is, can you make that Frank, instead of Johnny? [Laughter.]

Well, thank you very much. We will go on to the other witnesses here this morning.

Mr. David Kamens, Peer Educator, Washington, DC.

David, go ahead.

TESTIMONY OF DAVID KAMENS, PEER EDUCATOR, WASHINGTON, DC

Mr. KAMENS. Thank you.

Putting AIDS and HIV behind us—well, we cannot do that and I cannot do that. In July 1988, a month after my 18th birthday, I was diagnosed with AIDS and it was something that I did not think would happen to me.

Chairman GLENN. Do you have HIV now or do you actually have AIDS now?

Mr. KAMENS. I was diagnosed with CMV, cytomegalovirus, which is an AIDS opportunistic infection. At the time, I was very sick and I had come from a pretty sad state of despair, but I am doing well now.

At any rate, I travel all over the country speaking to peers; speaking to parents; working with doctors, nurses, and lawyers; and trying to help people understand how HIV relates to them and the importance for people to begin to understand and talk about this.

I think the most effective education we have is peer education. I think it needs to happen within the peer group. We talk about peer pressure, this awful negative force that drives kids to sex and drugs and all sorts of things, but I really believe that peer support can be the most powerful, nurturing, educating force that we have and I would like to use that, and I have seen some model peer education programs.

I grew up in Arlington, Virginia. I went to Yorktown High School here.

I think the hardest group for me to work with are parents. I spoke in front of a PTA a little while ago in the DC. area and the parents were angry. They were outraged. They said, "David, why can't you just say no? That's what we want you to say." I do not believe I can say that. I do not believe that is realistic.

Growing up is a trial and error process and kids experiment. I experimented. I became sexually active when I was 15 and I looked around me and started doing the things my peers were doing. I started using cocaine, I started smoking pot; the typical partying on the weekend. That was normal and it was what was going on around me.

I tried so hard to find a group that I could fit in with. A group of people that I could relate to; and I did. I put myself in unhealthy

situations over and over and over again, not realizing how self-destructive I was being. We think we are invincible. How and why can somebody, when they are 14, 15, 16, even 25 years old think about their own mortality? And that is not happening. We think we are invincible as I thought I was invincible and it was not something I thought I would have to live with, but I do.

We are not talking about high-risk groups, we are talking about high-risk behavior and everyone is at risk and I think we need to help people understand that. It is not a gay disease. It is not a disease that only affects the Latino community. It is something that affects all of us.

Through my work, I have seen positive results. I have seen kids' eyes just light up and start doing this work that I am doing for themselves and for their peers. I think one problem is we have these educational packets, some of them are adequate, some of them are not adequate, and schools are teaching them, but it is up to the comfortability level of the professors or the football coaches or whoever is teaching this information to include what they want and what they are comfortable with.

The thing about HIV education is that we are talking about sexuality, we are talking about experimenting, we are talking about growing up, and I believe the most effective way to do that is to use peers and peer education. Peer educators can relate to their peers as they know what the issues are.

I remember sitting in a classroom just 2 years ago in high school, listening to a doctor talk to the class about AIDS and it was going right over my head. I think it was going over my head because it was a scare tactic. That was being used, showing these awful slides and ugly pictures and stats and he was saying, "Don't do this! Don't do that! This is what's going to happen to you—don't have sex, don't do drugs," and I walked out of there thinking, "I don't have time for this, I already know everything."

I was pretty educated on HIV disease and what it was about and safer sex and transmission, but I think knowing and acting on it are two different things, and I think support from my peers is important and was important. I think it is important that kids understand they have a right to make decisions for themselves, that they have a right to make choices that they can live with, instead of people pointing the fingers at them and telling them what to do.

I also think that education has to come from all sides, it has to come from the family, it has to come from the school, starting in the lowest grades possible. It has to come from peer educators. It has to come from different government standards. So, I do not think it is just one person's role. I think it is something that we all have to attack and it is a challenge. It is a real challenge.

A student said to me last week, "David, if someone came to you and said you're okay. You know, respect yourself, love yourself. Would you have stopped using drugs and stopped partying and stopped experimenting?" I do not know, but it might have clicked in my head that I had a right to begin to think about taking care of myself.

When I walked down the halls at Yorktown I did not look like a druggie. I looked like a typical student. In fact, people called me "Mr. David Goodie Two-Shoes." I was not a typical drug user. I did

well in school, but I had another life; a life my parents were not aware of. A life some of my friends were not aware of, but it was really my way of coping and my way of fitting in.

Like I said, it is a challenge, but I think it is important that we are realistic and we need to be realistic about where young people are today, the growth process, experimenting. We need to be open when talking about bisexuality, homosexuality, heterosexuality as part of somebody's sexual self or just sexuality.

I have received some community opposition, but this is such a social disease and I think it is time, once we start talking about it and opening it up, we can become more comfortable with it. I have tried to break down the barriers and I am doing some of that work.

I guess one of the most important things is to include young people in this effort and to listen to them. To include them in the surveys, to talk with them and use them as role models for other peers. I think that is one of the best ways and one of the most appropriate approaches to this, because I really can see the eyes light up and I can see the young people listening to what I have to say.

Before I was sick, me taking care of myself was not an issue, and until it was a life or death situation, I had not heard or understood that I really had a right to respect myself and I really had a right to take care of myself, and it is sad that that is what it took. I see so many other kids out there who are going about living like they are going to live forever. We look at the people around us, too. I look at my teachers and my professors and the parents and the community; we respond to what is going on around us.

I was on a campus last week and I met with the faculty. They were all sitting around drinking cocktails, talking about the campus problems and the alcoholism on campus.

I just look around me and I see the models around us and that is what kids feed on, they pick up some of this stuff.

I look at the messages. I picked up a magazine last week and I opened it up and there was a picture of a sexy man and woman in their underwear toasting each other with a glass of vodka. What kind of message is that for young people? I fed on that and we do feed on that type of thing. I think it is important that we look at a lot of things.

HIV education and AIDS awareness encompasses so much and, like I said, it is an incredible task, an incredible challenge.

Chairman GLENN. Thank you.

Senator Kohl.

Senator KOHL. Thank you.

David, can you tell us, based on your own experiences, what you think the majority of kids believe and think about AIDS and how, if at all, their behavior is affected by these beliefs and knowledge? How do kids respond to this?

Mr. KAMENS. It is true, I do not think young people understand that HIV is their problem. I think we are still feeling that AIDS is a gay disease, it is not something that affects us. Through different stories, through some statistics and through sharing what I have learned with young people, I have begun to see them talk about it.

I cannot do it all and I do believe that the message is slowly getting out there. I do not know how much behavior is changing. It is a long process, a long road, but I am seeing some eyes open up and

increased awareness about STD's and HIV. But, generally, I would say there is still a common belief that this is something that "won't happen to me," but I think this is part of growing up.

We all think "that will not happen to me," whether it is AIDS or being killed in a drunk-driving accident or whatever, "it won't happen to me," and that is certainly what I believed.

Senator KOHL. In my opening statement, I talked about the mistakes that people made when I was young, the mistakes were never fatal as they can be now with respect to AIDS, drugs and drinking and driving while you are drunk and all of those things. The point was when you are 14 or 16 or 17, you are not in a position to make those kinds of responsible decisions, because you do not see life as being mortal, and I think you touched on that. So, what do you do about trying to help young people who are 13 and 15 and, in many cases, just simply unable, understandably unable to make those kinds of life and death decisions with respect to their actions? What does society do about responding to that human thing which is not changeable? You cannot expect a 13- or a 14-year-old to make those kinds of responsible decisions. What would you suggest?

Mr. KAMENS. True, you cannot, but I think we can begin to talk about self-esteem and self-respect and where that comes from. I believe that self-respect and self-esteem come from acting on decisions and experience. Young people making a decision, acting on it and seeing the results. Seeing that it was a responsible decision, the results were worthwhile, they can walk away from it feeling good about what they decided and who they are. I do not think it is an overnight process. It is part of growing up.

Senator KOHL. I was getting at something a little different. If a society like ours presents those options to young people as we are today, to some extent is it not almost inevitable that we are going to have the kinds of unhappy results that we do have?

Mr. KAMENS. I think to some extent we are going to see STD's and pregnancy and drunk-driving accidents. I cannot see that, you know, in the future, but I have found that through just greater awareness and talking about the issues, becoming comfortable with them, and addressing these things that we are not addressing is a start. I do not have the answers for that, but I do get letters after I speak with kids who say, "Thank you, David. You know, you opened my eyes to my behavior, I'm going to go out and do some of the work that you're doing. Thank you," and this is what makes it worthwhile for me. I think they feel the results. They can relate to what I am saying and where I was and where I am coming from and hopefully they will go out and continue some of the same work.

Senator KOHL. Thank you, Mr. Chairman.

Chairman GLENN. Thank you very much. David, yours is a very powerful message. I hardly know what to ask you. What reaction do you get from the community? You said you sometimes encounter resistance in the community.

Mr. KAMENS. Like I said, just 4 weeks ago I stood up in front of 150 parents in Arlington County and they were angry. They were one of the most misinformed groups I had ever spoken to. One woman said, "David, I cannot believe you are talking about respon-

sible decision-making skills and you're not just saying no." I said, well, that is not realistic, that is not realistic for me to say that. I said I am sexually active, I have done drugs, I have done all these things that are forbidden and are not going to talk about.

So, I understand where they are coming from, but I would say that from my peers, I get wonderful support and am met with wonderful compassion. I mean compassion and education is what we have, along with funds and scientific research. What I can do is educate and I can use the compassion that is there to help myself and help other people understand what this is about.

On a whole, yes, I have met some opposition, but I think it is derived from ignorance and misunderstanding. I have not met that much anger, it was only just a little while ago when I met with the parents.

Chairman GLENN. I think it would be nice if we lived in such a perfect society where you could say no and that was it and the problem solved itself. But the statistics I read into the record out of the GAO report were to me just sort of mind-boggling. I am not easily shocked any more, I will tell you that, but this thing was a real shock. I think the reason this hits me particularly this morning is that you are from Yorktown. We lived over there back in my days in the space program and my son was in the very first class that ever went to the new building at Yorktown.

Mr. KAMENS. I know that, sir.

Chairman GLENN. So, I am sitting here obviously this morning thinking what if.

Mr. KAMENS. When I was working with these parents before I spoke, they showed an educational video and this was through the Department of Health, and it was full of stats. It was about 4 years old. It had four profiles of people living with HIV and they all said, "Don't do drugs, don't have sex, this is going to happen to you, I'm going to die, it's a death sentence." It was very negative and that is what the parents wanted. They really wanted to show their kids this video.

One of the first things I said is, I am put off by this video, this is not what kids want to hear, this is what they turn off, this is what I now turn off and have turned off. I think we need to give information that is very sensitive to young people today and specific to different populations. I do not mean categorizing it, you know: the gay youth and the Latino community and the Asian community, but I do think we need to be sensitive, I really do. Like I said, we need to talk about sexuality and not give sex negative messages. I think this is really important. We are giving sex negative messages and I know kids who see these sex negative messages go, "Oh, that's bad, well, I have to try it," you know.

Chairman GLENN. You have spoken on college campuses. Do you get a different response on college campuses than working with your high school peers?

Mr. KAMENS. The younger the students are and the younger the people I work with, the more frank they are, the more interested they are. They have not been as inundated with information or see the headlines and they are more willing to listen. By the time they get to college, they do not turn me off and they are very active in participating in the dialogue, but I think they feel like they know

it all and this will not happen to them. They are already 25 and 26 years old sometimes and believe if they have made it to that point, it cannot happen, it will not happen.

Chairman GLENN. Thank you. We are going to have to move along. Your testimony has been fascinating. I wish you well.

The next witness is Ms. Wanda Wigfall-Williams, Center for Population Options, Washington, DC., and she will have a couple of other people she will also introduce for us.

Ms. Wigfall-Williams?

TESTIMONY OF WANDA WIGFALL-WILLIAMS, DIRECTOR, NATIONAL INITIATIVE ON AIDS AND HIV PREVENTION AMONG ADOLESCENTS, CENTER FOR POPULATION OPTIONS, WASHINGTON, DC,[1] ACCOMPANIED BY BRIAN BESS, PEER EDUCATOR, WASHINGTON, DC, AND RAHIM JONES, PEER EDUCATOR, WASHINGTON, DC

Ms. WIGFALL-WILLIAMS. Thank you, Mr. Chairman.

I am Wanda Wigfall-Williams, Director of the National Initiative on AIDS and HIV Prevention Among Adolescents for the Center for Population Options. This national initiative is funded, in part, by the CDC.

The AIDS and drug epidemics are gaining ground. Approximately 20 percent of reported AIDS cases are of people in their twenties. The long incubation period—up to 10 years—for the virus indicates that many of these people were probably infected with HIV during their teen years.

Although adolescents make up less than 1 percent of the total number of reported AIDS cases, the Centers for Disease Control reported a dramatic 42 percent increase in the number of adolescents diagnosed with AIDS between July 1988 and August 1989. Tragically, these statistics refer only to young people who have developed AIDS, not the unknown numbers of teens who are seropositive and asymptomatic.

Risk-taking behaviors, such as experimenting with drugs and engaging in unprotected intercourse, can result in deadly consequences. The need for HIV prevention and AIDS education is great. In our Nation's Capital, 1 in 300 adolescents tested positive for HIV—this was at Children's Hospital in 1988.

Chairman GLENN. What was that? Give that again, please.

Ms. WIGFALL-WILLIAMS. One in 300 adolescents tested positive for HIV. Yet, focus groups with area teenagers conducted by the Center for Population Options found that, while teenagers are aware of HIV and AIDS, many do not perceive themselves at risk of being infected.

It is difficult to protect the extent to which adolescents engage in activities that place them at risk for infection with HIV, as well as other sexually transmitted diseases. However, teen pregnancy rates can serve as one measure of sexual activity—one of the highest risk behaviors. Approximately 1 million teenage women become pregnant each year.

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[1] See p. 66 for Ms. Wigfall-Williams' prepared statement.

Parents, teachers, religious leaders, policy makers, health educators and youth have a responsibility to address this epidemic. CPO has developed a comprehensive program focusing on reproductive health, health promotion and "life planning" for adolescents.

In order to reach young people with motivating messages, practical information and accessible services, CPO approaches young people from a diversity of concerns and perspectives with reality-based, simple messages. We work through national, State and community based organizations to reach the largest numbers of youth, particularly those at greatest risk; we encourage multi-dimensional programs which provide formal and informal information and comprehensive health services; we create new programs, if needed, and evaluate existing ones to ensure that effective models are available to youth-serving professionals; and we assist opinion makers to reinforce messages and policy makers to support programs which prevent infection with HIV.

Peer education is one powerful approach to education for adolescents. Numerous studies have demonstrated that teens are more likely to ask their friends than an adult for information on a variety of topics, including health and sexuality. Often, peers are not only the main source of information for each other, they are the most influential in their ability to shape others' behavior. The peer group is a primary reference for values and behaviors.

In a focus group study conducted by CPO, inner-city adolescents said they would most likely listen to and believe what a person their age infected with HIV said about AIDS, rather than what an older person or a famous person said about AIDS or the virus. Further, an unpublished survey on condom use among adolescents found that teens' perceptions of other teens' condom use behaviors was the best indicator for determining their own condom use. In other words, if they thought that their peers thought using a condom was cool, they too would probably consider using a condom.

Recognizing the power that teens have over one another, and that this power can be used to influence teens' behavior in a positive way, CPO developed Teens for AIDS Prevention, otherwise known as TAP, to educate adolescents about AIDS and HIV prevention.[1] The TAP program provides 25 hours of skill-building training for a small group of peer leaders.

Once the TAP members complete the training, they create and implement activities in their school and community that focus on reducing misinformation, explaining consequences of and alternatives to risky behaviors, and increasing sensitivity to HIV infection and AIDS, including personal vulnerability, and ways to protect one's self from HIV infection.

It takes time to increase knowledge and change behaviors. Research indicates that simple, straightforward and reality-based HIV prevention messages delivered consistently by numerous sources, including peer educators, have a positive effect on changing knowledge, attitudes and behavioral intent.

Today, I am accompanied by Brian Bess and Rahim Jones from Ballou High School, located in Washington, D.C. As a result of

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[1] See p. 129 for a letter by the American Medical Association.

their involvement in the TAP program in their school, they have written a rap about HIV prevention and AIDS and they will perform it for you now.

Chairman GLENN. Good, we appreciate that. Where do you want to go, gentlemen? Come on up here, if you would like. Come up in this area right in here, so everybody can see you. If you could just stand at the side, then the audience can see you; present it to them and I will watch from the back. That is great.

[The following rap song was performed:]

Acquired Immuno Deficiency Syndrome,
I'll tell you straight up people it hits home.
It hits you hard and soon you know you're done for.
No rejoicing or praying you know the score.
I mean you can have AIDS you say you doubt it,
You or you with AIDS think about it.
I wanna milk this subject like I would a cow,
No ignorance needed just listen now.
Can you catch the disease by just shaking hands, from toilet seats, from meats, from touching, no you can't.
You should know shooting up would do you harm,
Injecting dope and disease right up in your arm,
I mean I pack me a rubber like it's a lucky charm,
So put you sex in check or else Joe your gone.
Because it can't be contained it'll spread around,
You're the problem won't solve 'em let me break it down.
Human Immunodeficiency virus,
You have to take high like Osiris.
C.P.O. and we will educate thee,
On the do's and don'ts of A-I-D-S, I want to express,
The negative trip that's coming from the rest.
Who thinks a subject like AIDS is just a gay click,
You're disillusioned, you're being stereotypic.
The needle drug users, the over abusers,
Are subject to AIDS and the accusers.
Male or female, gay or straight,
The AIDS virus doesn't discriminate.
Quote unquote D.D.P. for a while,
You just can't trust a big butt and a smile.
Not to be contacted from a kiss or cold sore,
Not to be given through the sweat of your pores,
Now that you know the information the score,
And if you wish it, I'll tell you more,
You see black, Latin Americans, white caucasians,
With the daily barbers, no discrimination,
A baby from when soon to come to an end,
You want to know why? Well, let me tell you, my friend.
Mothers abuse them, fathers just reuse them,
Shooting I.V. drugs, because it soothes them.
Everybody bopples, even to music,
But when the virus pops up, they start accusing.
But how about the baby who did no wrong,
Not the one you give the rattle, but the death song,
I mean would you beat your baby until they were dead?

Uh-uh, I didn't think so, so why don't you use your head?
Without protection, every time you get an erection,
Before you are the only man who has a yeast infection.
My friend. Please go on and learn to deal, and if you will,
Because it kills.

[Applause.]

Chairman GLENN. I understood Brian perfectly. I am not sure, Rahim, I understood you. [Laughter.]

That was excellent. What kind of response do you get when you put this on? I know all the kids get a kick out of the rap part of it, but what do they say about your message? Do they talk about it later, seriously?

Mr. BESS. Of course, it always has an effect like—it is not like me or Rahim are like so-called as the school likes to depict them, two nerds which have not been seen at school all year round——

Chairman GLENN. You do not look like nerds to me, I will tell you that.

Mr. BESS. I am the captain of Ballou's football team and Rahim is one of the co-captains, and we were involved in Ballou Against Teen Pregnancy, which was an organization created like in 1985, I believe, and we received no bad vibes from it at all. I mean our friends come to us regularly every day, students from Southeast Washington, if you want to say that, and they get the message. They like the rap, of course, but they always get the message and you always see the changes. The changes are very vivid, always.

Chairman GLENN. That is great. Rahim, the same thing, do they talk to you about it?

Mr. JONES. Yes. You have people who come out and ask us for condoms or they sit down and have talks with us. They are not afraid, but they do not want to go to anybody older than them, because they might not understand their point of view. They come to somebody their age.

Chairman GLENN. Yes.

Mr. BESS. The teen-to-teen concept is like real important. We had an overnight thing held by Jackie Sadler of D.C. public schools and we had people following us around the whole weekend, asking us to do the rap over an over again or either do other raps that we had, like teenage pregnancy raps or, you know, anti-drug raps or whatever, and it is just another ——

Chairman GLENN. How many subjects do you cover with your raps? Are you covering a number of different subjects?

Mr. BESS. Of course. You know, it is like——

Chairman GLENN. Rap is still a new concept. You talk about teenage pregnancies. What other things are you doing raps on?

Mr. BESS. Like I said, the teenage pregnancy rap we have just finished, because there are three people, really four people in our group, but me and Rahim were the only ones as far as the AIDS education went. Another member in our group, Danny Capers, he has been with us as far as like the drug raps and, you know, the teenage pregnancy raps. When I was in BATP, Ballou Against Teen Pregnancy, we had a rap, it was written by someone else, I cannot remember who, but what happened, we received the rap and you could tell it was a dull ring, you know, it was—I am not going to say it was an idiotic rap, but we had to change it around

to our liking, really. We had to change it around to our liking and we made sure that everyone else would like it, you know, and make sure the other students would hear it. We had to put it into high school or junior high school perspective.

Chairman GLENN. Have you done this in other schools?

Mr. BESS. Yes, me and Rahim, as far as us too, we just recently went to Bethesda-Chevy Chase, BCC, and that was done in front of the whole 1,300 students, but that performance there went on real well.

Ballou Against Teen Pregnancy, they said they were going to take it up, because the woman that was overseeing it was Ms. Gloria Odoms, she is not at Ballou any more. Before that, we did it at schools around the area like Hart Junior High School and Friendship, Johnson, and it was always the fact, when they see people that they might see—any city kids see people they might see on the streets and people they know have that—let me see how I can put it—status, I would say street status, but people that are known to be good people or whatever and they see them delivering this message and it gets to them and they see nothing wrong with it, because a lot of students have a fear, well, I am not going to follow this, because nobody else is following that person, so why should I follow that person. But if you see that dominant leader role and they see somebody that is on the popular level, they tend to follow it, really.

Chairman GLENN. Have you recorded this or put it on tape or a record, so other kids can benefit from it, too?

Mr. JONES. We are on the verge of putting it on a record. It is recorded on tape, our personal tape.

Mr. BESS. But as far as like being given out for a record company——

Chairman GLENN. Have any of the local radio stations picked it up?

Mr. JONES. No.

Chairman GLENN. Ms. DuVall, are you going to invite them down to New Orleans?

Ms. DUVALL. Absolutely. Listen, we have quite a few rappers down there ourselves. I think it was great, what the gentlemen did and, as they said, that is exactly the point I was trying to make, we have got to hit home, it has got to be told as the students and the children will hear it and listen to it and heed it. You guys, hang in there. It sounds great.

Chairman GLENN. Obviously the first thing you have to do is get people's attention. I was looking from behind you at the audience while you were doing your rap and you had the whole group right there with you. I can tell you that this is the first time that has happened in this hearing room. I would like to invite you guys back for a lot more hearings on different subjects.

Thank you. That was excellent. I am glad to see this. We are going to have to move along. Mr. Kamens, I appreciate your being here this morning. It is a very personal thing for you and we wish you well, all of you. Ms. DuVall, thank you for being here this morning.

Ms. DUVALL. Thank you for having us.

Chairman GLENN. The next panel is Gary Noble, Deputy Director (HIV), Centers for Disease Control, Atlanta; accompanied by Ms. Virginia S. Bales, Deputy Director of the Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control; and Dr. Lloyd Kolbe, Director, Division of Adolescent and School Health, Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control.

We welcome all of you this morning. Dr. Noble, if you would lead off, we would appreciate it. Thank you. If you want to put on a rap demonstration, we would welcome that, too, this morning.

Mr. NOBLE. I would not dare. [Laughter.]

TESTIMONY OF GARY R. NOBLE, M.D., ASSISTANT SURGEON GENERAL, AND DEPUTY DIRECTOR (HIV), CENTERS FOR DISEASE CONTROL, ATLANTA, GA.,[1] ACCOMPANIED BY VIRGINIA S. BALES, DEPUTY DIRECTOR, CENTER FOR CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION, AND LLOYD KOLBE, M.D., DIRECTOR, DIVISION OF ADOLESCENT AND SCHOOL HEALTH, CENTER FOR CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

Dr. NOBLE. Mr. Chairman, I appreciate the opportunity to be here and would like to thank the Chairman and the members of the Committee for focusing attention on this very important problem.

Chairman GLENN. We welcome you back again. You have been here before. You were a witness before the Committee back, what was it, a year ago?

Dr. NOBLE. Two years ago.

Chairman GLENN. Two years ago. Time passes.

Dr. NOBLE. I am Dr. Gary Noble, the Deputy Director of the Centers for Disease Control, with responsibility for the HIV prevention programs at CDC. I am pleased to have this opportunity to discuss CDC's efforts to help prevent HIV infection among school-aged youth.

I am accompanied today by Ms. Virginia Bales, Deputy Director, Center for Chronic Disease Prevention and Health Promotion, and Dr. Lloyd Kolbe, Director, Division of Adolescent and School Health, who helps direct the CDC programs to prevent HIV infection among school- and college-aged youth.

In October 1986, the Surgeon General of the United States, Dr. Koop, called for schools to teach our Nation's youth about the risks of becoming infected with HIV. In the same month, CDC's program on school health education, to prevent the spread of HIV infection was initiated.

The primary purpose of CDC's program is to prevent HIV infection among youth. CDC's programs are designed to build the capacity of schools and other youth-serving organizations, to implement effective education about HIV that is consistent with community values and needs.

Why is HIV prevention education so important for our youth? CDC is concerned about the extent to which teenagers and young

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[1] See p. 72 for Dr. Noble's prepared statement.

adults are at risk for HIV infection. We know that 1 out of every 5 persons reported with AIDS in the U.S. was between the ages of 20 and 29 when diagnosed, and with the incubation period being, on the average, 10 years, that means many of those were infected before the age of 20.

We know about the sexual behaviors, and we have heard this morning about the high rates of STD and unintended pregnancies. These are often interrelated problems, and they are often behaviors that are established during adolescence. This is a critical population to reach, if we are to improve the health of the Nation.

We think that educational programs to prevent HIV infection and other important health problems can be most effective when they are implemented as part of a planned sequential, kindergarten through grade 12 program of comprehensive school health education.

The Nation's schools provide an existing and efficient system to reach almost all young people during the ages when they are most impressionable, and to reach many young people who may ultimately drop out of school. That is one reason why CDC has invested in helping the Nation's schools to provide effective HIV education. We need to remember that virtually all out-of-school youth were at one time in a school environment.

Let me describe some of the CDC programs to reach school-aged youth. We have established a multi-faceted program that combines the work of national health and education organizations, State and local education agencies and health departments, numerous community-based organizations, and our own National AIDS Information Education program.

CDC has been working to help schools provide comprehensive school health education since 1974. In 1986, to fill the gap in the Nation's HIV prevention strategy, CDC's core staff in school health education, then numbering only four, began planning a nationwide program to prevent HIV infection, specifically among school-aged youth.

In September 1987, with a budget of $11 million, CDC launched its program of school health education to prevent the spread of HIV infection by providing support to 15 national organizations and to 15 State and 12 local departments of education that serve the jurisdictions with the highest cumulative number of reported cases of AIDS.

By the fall of 1988, with a budget of $30 million, CDC was providing fiscal and technical assistance to 19 national organizations, and all 50 State and 5 territorial and 16 local departments of education. By fiscal year 1989, the budget had increased to over $35 million, and today, in fiscal year 1990, CDC has a staff of 45 and a budget of $45 million to help prevent HIV infection among school-aged youth.

I have been told by others that CDC has the finest collection or one of the finest collections of experts in this area in the Nation. The request for fiscal year 1991, totaling over $52 million, will allow CDC to improve its assistance for its in-school programs, as well as to expand its efforts for out-of-school youth.

CDC requests each year that the State and local education agencies funded by us develop four objectives to assure that school-aged

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youth receive HIV education: First, to increase the number of junior and senior high schools that provide HIV education; second, to increase the number and percentage of junior and senior high school students at each grade level who receive HIV education; third, to increase the number of junior and senior high schools that integrate HIV education within a more comprehensive school health program; and, fourth, to increase the number of other agencies that implement HIV education for high-risk youth, minority youth, out-of-school youth and youth with special education needs.

We also request that these funded agencies collect data on an annual basis to measure their progress in meeting each of the four objectives described above.

About 9 million youth, ages 14 to 21 years, do not attend school or college and may be at greater risk of HIV infection than their peers who are in school and college. I would say that the real figure of street and homeless youth is not known, but it is probably in the range of a million. To reach these youth effectively, a variety of activities from several program areas are necessary.

Let me describe some of the activities of the Center for Chronic Disease Prevention and Health Promotion to reach out-of-school youth. For example, five national organizations that receive CDC funding develop and implement educational programs for out-of-school youth and provide training to staff working in agencies that serve out-of-school youth. Over 75 percent of the funded State and local departments of education are carrying out activities to assist agencies that serve out-of-school youth in their jurisdictions to implement HIV prevention education.

Finally, a training and demonstration center in San Francisco has conducted 12 training and demonstration programs for over 400 staff serving out-of-school youth from 35 States, in 74 cities. Let me say that, in addition to the Center for Chronic Disease Prevention and Health Promotion, which is represented here today, there is a coordinated effort at CDC.

The office that I direct coordinates and provides leadership for the HIV prevention programs throughout CDC, including those that reach out-of-school youth. Our office is the focus of the prevention efforts in this population, coordinating work of the Center for Chronic Disease Prevention and Health Promotion, the Center for Prevention Services, and the Center for Infectious Diseases.

The Center for Prevention Services has cooperative agreements with State and local health departments, as well as with minority and other community-based organizations and with the United States Conference of Mayors, and these are implementing programs to prevent HIV infection, many in out-of-school youth.

The Center for Infectious Diseases is currently conducting blinded HIV serosurveys of homeless populations, including youth in 11 cities throughout the country, and we would be glad to expand on some of the evidence that has been found in those serosurveys.

In fiscal year 1991, CDC is planning to help local health departments in three to six cities with the highest number of AIDS cases build more effective and coordinated HIV prevention programs for out-of-school youth. In addition, we will be funding increased support of relevant community-based organizations in these high-inci-

dence cities to develop and evaluate intensive HIV programs for out-of-school youth.

In summary, CDC began its program to stimulate health education for children in this country with a small staff of four and a budget of $250,000. In 1990, the program consists of 45 staff members and a budget of $45 million. These resources have enabled every State and several major cities to have the capacity to put in place programs to prevent HIV infection among school-aged youth. Through activities such as program planning, developing policies, and training teachers, the State and local levels will help prevent a new generation of AIDS cases.

Thank you, Mr. Chairman.

Chairman GLENN. Thank you very much, Dr. Noble.

Does CDC have an estimate for the percentage of teenagers currently infected with HIV? How do you arrive at figures like that? Do you have figures you feel are fairly accurate?

Dr. NOBLE. Well, the best way to get information on this is through various seroprevalence surveys. We have discussed, of course, the possibility of a national household seroprevalence survey, but that would not reach many of the populations we are talking about. We have a national family of surveys, which includes blood samples taken from over 40 hospitals; these are randomly selected admissions at all ages. Of the first preliminary data that we just analyzed, we find that in the 13- to 18-year-old group, in 26 hospitals in about 26 different States, the rate of infection is about 1 in 1,000. In the 19- to 24-year age group, males have a rate of infection of about 1 in 250, and females, about 1 in 1,250.

Regarding military recruits, there are tens of thousands of young people applying for military service, and the Department of Defense has analyzed their data and published it recently. They find that in the urban counties of Maryland, Texas, New York, and the District of Columbia, for example, the rates in the under-20 age groups is 20 times higher than it is in the upper Midwest. That demonstrates the major differences between geographic areas in the United States.

There are also, as we have heard this morning, major differences in the prevalence of infection in different racial and ethnic groups. Among black applicants for military service under the age of 20, the rate is about 1 in 1,000. It is five times higher than the rate in white applicants for military service.

Chairman GLENN. Do you find a difference in willingness to give data on this or to respond to surveys? Is there a difference from one part of the country to another?

Dr. NOBLE. We have had some initial reluctance in implementing the family of surveys, but that has improved over time.

Chairman GLENN. I was going to ask a surveyor, and I did not get around to it, but they are still in the room, Ms. Rosengren and Mr. Landry. Ms. Rosengren, you come from what is looked at as super-liberal Boston, and Mr. Landry, you come from Atlanta which is looked at as sort of a center of conservative thought for the country by a lot of people. I do not not necessarily think that way, of course, but that is the way a lot of people look at those two cities.

You two have talked, I am sure, about your difficulties in obtaining information. Do you find differences in your two parts of the country? This is a little unusual, but you can stand up and make yourself heard at the microphone, if you would.

Mr. LANDRY. I might have to think about that for a second, Senator. As I think about the school districts we called, 93 percent of the school districts were willing to talk to us, so they were real open with telling us what their policies were and where they were. That is all I can think of right at the moment.

Chairman GLENN. Ms. Rosengren, what is your percentage that would compare with that? He has got 93 percent in Atlanta, do you have better than that or less than that?

Mr. ROSENGREN. I personally did not look at that issue, but we have heard that private schools are providing more in the way than public schools.

Chairman GLENN. Okay. Good. Thank you both.

Dr. Noble, GAO has made some specific recommendations that I would appreciate your comments on. Now, we have a lot of school districts nationwide that do not offer HIV education. What is CDC going to do to try and correct that?

Dr. NOBLE. Well, we have made it very clear in the announcements of the availability of our funding that we expect schools to have age-specific education right through the grades and, as I have mentioned in my testimony——

Chairman GLENN. All of them including 11 and 12?

Dr. NOBLE [continuing]. That we have specifically requested that each of the applicants address the gaps in all age groups and have as a target an increase in each grade, including the 11th and 12th.

I would say that we really do feel that this is important, as the Surgeon General Dr. Koop said in October 1986, on the release of his report. At the time, it seemed rather controversial that there should be age-specific education right down to the youngest ages where this information can be understood. We believe it should be part of a comprehensive educational program. We do not feel that at the Federal level we have the opportunity to require specific education. The control over content of materials presented to our youth throughout the history of our Nation has been very jealously guarded by local authorities.

Chairman GLENN. When will guidelines be issued for teacher training in HIV studies? I think that has been a criticism of CDC; no guidelines out yet after all this time. Why not?

Dr. NOBLE. Well, I would say that in January 1988 we did issue recommendations for education of teachers. We published specific information that should be taught to age groups, each age group, and we feel that each teacher should be familiar with that information. We believe that the teachers, in order to teach the information, as any teacher teaching any subject, must be knowledgeable.

We have not specifically required certification or standards, again because that is not generally viewed as a Federal responsibility, but we have made it clear and we intend to make it even more clear that the content that should be provided for each age group is well documented in the publication that we put together in collaboration with many national and regional health organizations,

called "The Guidelines for Effective School Health Education to Prevent the Spread of AIDS," published in January 1988.

Chairman GLENN. There has been a lot of comment about whether some of the material being used is adequate or not or whether it is doing the kind of job that it should do. There has been congressional activities, you may be aware of, back and forth from time to time on what was permitted to be put out, and I think we have come to a better resolution of that now than we had at first.

Health and education officials back in my home State of Ohio and representatives of other federally funded organizations do not feel they are getting adequate support for clear and explicit language for AIDS education, including the America Responds to AIDS Campaign. What do you plan to do to make sure that this message is carried, that we can convey a stronger message, and what can be done to allow the State agencies and organizations to convey that stronger message?

Dr. NOBLE. We feel that it is absolutely important to have clear messages. We have heard this morning from some of the witnesses on the importance of words that speak to the intended audience. At the same time, we live in a pluralistic society that has a variety of views about what is acceptable, and we must deal with the balance there.

Part of our overall education responsibility at CDC and in other parts of the government is to help to change not only the peer values at the teenage level, but, if I may say, at all levels of our population, among community leaders, and even among members of the Congress and the Executive Branch; we hope to create the appropriate climate that allows people to accept the need for very clear messages. It is a difficult area, and we aim to clear these messages promptly for those national groups that are trying to provide clear messages. We have as a goal a turn-around of 12 weeks in reviewing these documents.

However, I would say that for materials produced by the State and local groups that are funded, for example, by our Center for Prevention Services, we do not review those at CDC. We provide guidelines and expect panels made up of members of those communities to decide what is appropriate for their communities, because what is acceptable in New York City may not be acceptable in the Midwest.

Chairman GLENN. We are concentrating this morning, of course, on school-age populations, those in and out of school and what works and what does not and what the programs are. The same need exists for getting information, of course, on adult programs, as well. Can you tell us what proposals CDC has or has under consideration for improving the data on other than our teenage and school population?

Dr. NOBLE. I am sorry, improving the data on?

Chairman GLENN. On the adult population with regard to HIV and AIDS. In other words, we are concentrating on schools this morning, but how about your information on out-of-school people, the adults, the general population? They have been one of the barriers to getting back your data. How are you coming on that? What is the status of that?

Dr. NOBLE. Collecting information on the prevalence of infection or getting out the message?

Chairman GLENN. Both.

Dr. NOBLE. We feel it is very important to track the course of the HIV epidemic. As the Presidential Commission on the AIDS Epidemic said, this really is an epidemic of HIV infection, not just an epidemic of AIDS, and that is why we are implementing a family of surveys that includes a wide range of things. Every child born in over 44 States has antibody testing at birth to determine the prevalence of infection in the mothers.

Chairman GLENN. The figures I read this morning, I think you were in the room when I read those, about the sexual promiscuity and the patterns and the percentages as estimated by GAO for the school-age population, do you have similar figures for the general population at-large?

Dr. NOBLE. One of the difficulties of getting information about sexual behavior in adults has been the issue we have dealt with earlier today, and that is the reluctance of many people to openly discuss these questions. We believe that a national survey of behaviors that put people at risk, sexual and drug-use behaviors, would be very useful, and we are looking forward to working with Congress [on] a national survey that would provide that information.

There are other ways of getting that information, and our colleagues in the Center for Chronic Disease Prevention and Health Promotion have been doing surveys of behaviors. As you have heard this morning, it began with a small number of States, but it is now up to 33 States that are implementing surveys specifically for sexual behavior.

Chairman GLENN. What kind of support have you received or not received from HHS and from OMB for collecting information like this on the general population? Have they supported your efforts to get that kind of information or opposed it?

Dr. NOBLE. In general, the decision has been left to the Department, that is—what is the status—the negotiations specifically on the survey of behaviors are being considered within the Public Health Service and the Department. There was, as you know, a congressional statement that no funds should be used for such a survey.

Chairman GLENN. But has HHS not supported your efforts?

Dr. NOBLE. They have supported these efforts.

Chairman GLENN. They have supported you. How about OMB, have they given you the money for this?

Dr. NOBLE. Yes. I am not sure specifically which request you may be referring to, but——

Chairman GLENN. As far as really getting these data collection programs underway, you are receiving full cooperation out of HHS and OMB. Is that right?

Dr. NOBLE. Yes, I would say yes.

Chairman GLENN. All right.

Dr. NOBLE. I would add specifically that OMB has approved the survey that I mentioned for collecting information on sexual behaviors among the youth.

Chairman GLENN. From 1987 through 1990, the President requested in his budget for HIV school education essentially what

the Centers for Disease Control had requested. For fiscal 1991, however, CDC requested $76 million, but the President only submitted a budget request for $52 million. What is going to get left out? You obviously had plans for that $76 million. What is going to get left out, if you are only granted $52 million?

Dr. NOBLE. The primary intent of that information was to target out-of-school youth. I might ask my colleagues to amplify that.

Ms. BALES. The entire budget request for school- and college-aged youth, the increase was to target out-of-school youth. We were very successful in getting an initiative included in the President's budget which is now before Congress for out-of-school youth. The difference between the amount that CDC requested and the amount that is in the President's budget was also to be directed to out-of-school youth.

Chairman GLENN. The figures I gave would be $24 million short of what you wanted. Is that correct?

Ms. BALES. That is correct.

Chairman GLENN. So, you just will not be able to go after the out-of-school targets the way you wanted to?

Ms. BALES. We will, but not as intensively and not in as many cities as we might have been able to reach with a larger budget.

Chairman GLENN. Was the reason for this strictly budgetary or were they unhappy with your program?

Dr. NOBLE. My understanding is it was simply budgetary.

Chairman GLENN. Okay. It is my understanding, the average grant to States and local education agencies to date has been $260,000 and they have been told not to expect an increase in funding for 1991. Is that your understanding?

Dr. NOBLE. Yes.

Chairman GLENN. How about money that went unspent? Last fall, the Cleveland Plain Dealer reported that $34 million CDC provided to State and local health departments for 1988 had been unspent. Was that rectified? We are not pushing people to spend money just to spend it because it is there, but what was the reason that money was not spent? We sure have a problem out there. We thought we were helping them take care of it by addressing the problems with out-of-school, school programs, adult programs, and others, but the money is still sitting there in the accounts. What happened?

Dr. NOBLE. The article you refer to in the Cleveland Plain Dealer dealt with funds given by our Center for Prevention Services, and I would say several things. First, that money will be spent. It obviously is not going to go down the drain.

Second, I would say we have a balance between the urgency for getting money spent and the concern for spending it wisely, for spending it within the direction, the guidelines, given by Congress in the appropriation. There are a variety of reasons why many of our programs funded by CDC have carryover funds. It is not uncommon in our tuberculosis control programs, our immunization programs, our STD control programs, to have carryover funds. In some ways, a certain amount of carryover might be considered actually a responsible management of money. We are concerned [about reducing] that to the lowest amount.

Some States have constraints on spending the money efficiently or quickly. For example, there may be hiring freezes, there may be problems with legislative authority. I was at a meeting in Charleston yesterday with representatives from around the United States representing State and local health and education agencies, and a colleague from one of your neighboring States mentioned that at the time the funds were received from CDC, there was a bottleneck in the State legislature concerning school education programs that had to be resolved before they could proceed with the expenditure of those funds.

So, it is a problem that we are concerned about and work to reduce, but there will be an inevitable minimum amount of carryover in all programs.

Chairman GLENN. What are you doing to see that school districts conduct KBB, knowledge, beliefs and behavior, studies of their students?

Dr. NOBLE. Let me ask Ms. Bales or Dr. Kolbe to address that.

Chairman GLENN. Dr. Kolbe, we have not heard you yet this morning.

Dr. KOLBE. Mr. Chairman, we do a number of things. Firstly, we were actually requested by the State and local education agencies with which we work to help them develop one common instrument, so they could all work together and determine the kind of instrument that they could each use, so they can compare their data amongst each other.

We provide technical assistance to them with our research staff out of CDC, but, in addition, we provide technical assistance through a contract with Westat Associates. It is difficult to define a sampling frame to go out and collect data and to analyze that data, so that they have support actually to do the technical work.

Chairman GLENN. Do you ever consider withholding a State's HIV funds until these KBB studies are completed?

Dr. KOLBE. We would not. We think that it is important for the States to collect these data and we provide every assistance that we can, but we do not think it is the Federal role to demand that the States provide these kinds of data, to collect these data, especially when those funds are urgently needed, no matter whether they collect the data or not.

Chairman GLENN. Do you people provide any guidance to the States on how they might distribute their Federal funds?

Dr. NOBLE. Yes, indeed. Each State is expected to provide to us reports, and they, in turn, expect to have accountability from the local school districts plans must be submitted by the organizations within the States that use those funds.

Chairman GLENN. The reason I ask is, with the grant it receives from CDC, the State of Maryland, for example, requires school districts to apply to the State for separate grants which may range from over $10,000 to as low as $3,000. Not all school districts apply or get in the ball game. Does that system make any sense to us? Should there not be some guidance maybe on how the funds are to be used?

Dr. KOLBE. There is guidance for how the funds are to be used. In that particular case, the State of Maryland does provide through its State Department of Education activities, resources, support,

:e to all of the schools in that State, but then, in addition to that, there are particular schools that want to launch their own demonstration activities, so it is a combination approach in that State.

Dr. NOBLE. We do need to work on sensitizing all school districts that there is a need. I think we have heard earlier that some people still believe that it is not their problem and that is an issue we have to recognize and deal with.

Chairman GLENN. We are going to have to move along. We appreciate your being here, all of you. Thank you very much.

Dr. NOBLE. Our pleasure.

Chairman GLENN. We are going to have to move along to the next panel. I have to be over on the floor at just before 12:00 o'clock, so we are going to have about 20 minutes here for the last panel and we have four members of that panel that we welcome this morning. My time constraints do not reflect any lack of interest in your presentations this morning, I can assure you.

Our panel this morning is Ms. Patricia Brownlee, AIDS Education Facilitator, Baltimore City Public Schools; Ms. Katherine Fraser, Program Director, AIDS Education Project, National Association of State Boards of Education, here in Washington; Ms. Sandra McDonald, President, Outreach, Inc., Atlanta, Georgia; and Mr. Jay Coburn, Director, Safe Choices Project, National Network of Runaway and Youth Services, of Washington, DC.

Ms. Brownlee, if you would lead off, please. Any statement any of you have will be included in the record in its entirety. We would appreciate a summary this morning, so we can get to everybody, and I am sorry I do have these time constraints. Ordinarily, we would run over with whatever time was required, but we cannot do it this morning. I have to be over there to floor manage a bill in the Senate.

You may lead off, please.

TESTIMONY OF PATRICIA J. BROWNLEE, AIDS EDUCATION FACILITATOR, BALTIMORE CITY PUBLIC SCHOOLS, BALTIMORE, MD [1]

Ms. BROWNLEE. Mr. Chairman, thank you for the opportunity to testify today as part of the committee's hearing on HIV prevention education, serving in- and out-of-school youth. My name is Patricia John Brownlee and I am the AIDS Education Facilitator for Baltimore City Public School System, in Baltimore, Maryland.

Baltimore City Public Schools receives funding for AIDS/HIV education through a cooperative agreement with the Center for Disease Control, Division of Adolescent and School Health. Requests for funding have been made annually since 1987.

With the funding support from CDC-DASH, a specific AIDS/HIV prevention curriculum consisting of three lessons at each level, in grades 3 through 12, have been integrated into a comprehensive health education program. Baltimore City Public Schools has been able to initiate and maintain a model AIDS/HIV education program, impacting nearly all of the 108,000 students enrolled. Com-

[1] See p. 102 for Ms. Brownlee's prepared statement.

municable disease prevention is taught in kindergarten through grade 2 with HIV infection presented as part of the larger body of communicable diseases.

The construction, writing and printing of the curriculum was supported by CDC–DASH funding. To assure and reinforce the success of the HIV curriculum, extensive teacher training has been provided, through in-service workshops and college courses. Funding for substitutes to promote teacher attendance at workshops and stipends to defray tuition costs have been provided to teachers through CDC–DASH funding.

Support and supplemental materials, videos, pamphlets and updates have been provided to teachers responsible for AIDS prevention education. These various materials are on-site in each of our 178 schools offering maximum accessibility and motivation for use. The lessons in the curriculum provide for specific use of these A–V supports.

Numerous parent and community group presentations have been made to raise the awareness of the surrounding communities. Through heightened parent awareness, in-school youth and out-of-school youth have been reached. Follow-up presentations are encouraged.

Reaching out-of-school youth with HIV prevention messages is a more complex undertaking and requires creative techniques for facilitation. With support from CDC–DASH, several programs have been initiated in Baltimore City.

Five Baltimore City public school teachers serve as outreach workers at the Francis Scott Key Medical Center Adolescent Detoxification Unit to deliver HIV prevention messages, as well as safer sex and other health information to the young patients. These teachers average between 20 and 22 hours per week of instruction.

A unique project has been initiated in the community of Cherry Hill, a subdivision of Baltimore City. Through collaborative effort between the American Federation of Teachers, also funded by CDC–DASH and Baltimore City Public Schools, three outreach teams, consisting of one teacher and one paraprofessional, have been formed and trained to present HIV messages to parent, church and other interested groups. This project has been so successful, that it will be expanded to other high-risk areas in Baltimore City, using Cherry Hill as a model.

A pilot peer education program utilizing 10 students from a Baltimore City Health Department "at-risk" youth education group was successfully initiated during the summer of 1989. The participants were trained in communication skills, HIV prevention education, empowerment skills and refusal techniques. As peer educators, these students made presentations at 27 sites, libraries and recreation centers, to well over 800 in- and out-of-school youth. This program will operate once more this summer, using the same peer educators as trainers for new peer educators. This program will also be expanded to service in-school youth in middle school in September 1990.

Reaching out-of-school youth is difficult and more costly than reaching the larger population of in-school youth. For example, the Francis Scott Key program will cost approximately $20,000 this

year to service about 250 youth. This is 9 percent of my total budget to reach a relatively small number of youth.

The AIDS education program in Baltimore City Public Schools has been successful for several reasons. The messages begin early and are repeated consistently through all grade levels. If we consistently teach self-esteem building and self-concept raising techniques, our students will be in a better position to make positive choices in health, as well as in other aspects of their life.

Most young people do not use their knowledge base to make decisions concerning sexual behavior. It is important to teach our young people skills that they can put into action when faced with compromising situations where a decision must be made.

Giving a definite message about abstinence from risk behaviors is important. Peer pressure is extremely strong in adolescence. An unclear message gives no direction and the youth will follow peers, which may or may not be a healthy path.

A one-time HIV prevention presentation for students is not satisfactory. Students need consistent, repeated messages about HIV prevention. Through past experiences in teacher training, it has been determined that a one-time presentation for teachers is far from satisfactory. Training must be consistent and occur often with an initial "dose" and frequent follow-ups thereafter.

In a large system, there is also the lack of appropriate personnel to accomplish mammoth tasks involved in HIV education. There are also varying readiness levels of administrators and teachers in dealing with HIV/AIDS information, and differences in perceived relative importance of the subject.

HIV prevention education works best when integrated into a comprehensive health education curriculum. There needs to be continuity so that good health decisions become a part of life processes and behavior.

Federal, State, and local governments can assist in the following ways: Mandate comprehensive health as a graduate requirement for all high schools seniors; mandate that health education be taught by well-trained health educators; provide increased funding for teacher training; provide increased funding for instructional support materials due to rapidly changing information about HIV infection; provide financial support for activities targeted to reach minority and out-of-school youth; and provide additional financial and technical support and opportunity for networking with national organizations to existing HIV prevention programs.

In summary, CDC funding, technical assistance and networking support provides the impetus for school systems to produce viable HIV prevention programs for both in- and out-of-school youth. Assistance in these areas from CDC-DASH has been instrumental in Baltimore City Public Schools' HIV education effort for both in- and out-of-school youth and the community at-large.

Thank you.

Chairman GLENN. Thank you very much.

Ms. Fraser, would you go ahead, please?

TESTIMONY OF KATHERINE FRASER, PROGRAM DIRECTOR, AIDS AND COMPREHENSIVE SCHOOL HEALTH PROGRAMS, NATIONAL ASSOCIATION OF STATE BOARDS OF EDUCATION, WASHINGTON, DC.[1]

Ms. FRASER. Mr. Chairman, I am Katherine Fraser and I am Program Director of the AIDS Education Project for the National Association of State Boards of Education. I am pleased to be here today to talk to you about what our organization, as one of the national organizations that CDC is funding, is doing to promote AIDS education.

We assist State Boards of Education, the policymakers who are charged with outlining the response of State Education Agencies to the AIDS epidemic. We provide direct, on-site technical assistance, we produce publications that help in policy development, and we help provide national leadership about the AIDS epidemic and the health crisis underlying it.

Our State Board of Education members believe that AIDS is part of a bigger issue that concerns other health problems of our young people. They are concerned that health problems are interfering with students' ability to learn, their motivation to graduate from high school, and their readiness to take their place in the world.

Teenagers who are depressed, who are alienated or taking drugs, or who feel like they have no future are at risk of school failure. For us, this means that schools need to be much more involved than they ever have been in the past with supporting the health and emotional well-being of students. Many people will disagree with this idea, because they will think that the school's role is to strengthen academic achievement and not stray into the health field. But we believe that schools must be partners with families and communities in doing this.

With CDC support, we have formed the National Commission on the Role of the School and the Community in Improving Adolescent Health. The Commission is composed of leaders in health, education, the media and business and will issue a report to the Nation with concrete recommendations on June 8th.

Also with our CDC grant, we have become a national and an international center for information about AIDS and education. Last year, we produced a publication, "Someone at School Has AIDS," that has been requested by 17,000 organizations and individuals in the past 6 months. It has been the basis for many State and local policies for people with AIDS that are medically correct and compassionate.

We also help States develop AIDS education policies and, through our surveys, we have learned about the impact of our work. In the summer of 1987, seven States required AIDS education. Now, in May of 1990, that number has increased to 30 States and the District of Columbia.

I want to tell you that I have been working closely with the Centers for Disease Control and the Division of Adolescent and School Health for 3 years and I think their program is first-rate. Like any innovative new program, it has had its growing pains, especially

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[1] See p. 107 for Ms. Fraser's prepared statement.

since it was dealing not only with a public health issue, but a very emotionally and politically charged issue in the States.

As the program progresses, I have two main recommendations that would address the problems that are reflected in the GAO report. First of all, that CDC continue to draw upon its national organizations and the strength that it has built there, to educate their constituents in the States about the importance, for example, of conducting surveys, of making sure that 11th and 12th graders are educated about AIDS, of making sure that rural schools are giving AIDS education, and to support teacher training.

I would also suggest that, as CDC continues to strengthen State education agencies, that it also build links with other State agencies and with legislatures and governors. Many States that have made a very strong commitment to providing AIDS education have had the support of their legislators and governors. It is these people whose hearts and minds must be won in order to develop a comprehensive approach to this epidemic.

I want to thank you for your leadership on this issue. It helps organizations like ours and it has been a pleasure to be here.

Chairman GLENN. Thank you, Ms. Fraser.

Ms. McDonald.

TESTIMONY OF SANDRA McDONALD, FOUNDER AND PRESIDENT, OUTREACH, INC., ATLANTA, GA [1]

Ms. MCDONALD. Thank you very much, Senator Glenn, for giving us this opportunity to come before you.

I am President and Founder of an organization called Outreach, Inc., of Atlanta. It is a minority community based organization formed 4 years ago to address the needs for HIV education of the minority community. It is the first minority organization started in the State.

We use traditional and non-traditional approaches to provide our education and on our staff we have 15 recovering IV drug users and five persons with HIV disease. We have an in-school and out-of-school program and I would like to talk a little bit about what we have seen with our out-of-school activities.

You asked earlier what works and what does not work and, in my few minutes, I am just going to address that. What works is peer-to-peer level education; what works is David's testimony that I am 19 and I am HIV positive; what works are rappers who are young leaders, football players in their schools who are looked up to by other kids, who will say it is not cool to do this, you really need to know about AIDS.

What does not work are programs designed by adults for teenagers who have no feel for what is important to them and what is not; what does not work is just "don't say no," because no is not in the teenagers' vocabulary, plus it is not in our vocabularies, so what we expect of them is not what we do ourselves.

What I often have to remind myself and others is that the kids that we are calling teenagers today were born in the seventies, when those of us who were in our twenties and beyond experienced

[1] See p. 111 for Ms. McDonald's prepared statement.

our sexual revolution. So, what they were able to see and what they were able to put back to us in the sexual revolution or drug usage, it used to be very popular in the hippie generation to smoke dope publicly. These kids were 2 and 3 then and they remember those kinds of things, or parents who drink all of the time. If those kinds of messages, that that is what you see at home, it is very difficult to go to a school setting and hear this boring lecture about just saying no, because you do not see anybody practicing no. In the seventies, we were not using condoms. Our kids are just getting exposed to condom use, how to use them and all.

What works is talking straight. What one of our problems is the restrictions that we have on Federal money, to not be able to talk to kids on their level, to not be able to use culturally sensitive slangs which might be our only way of getting messages across. It would be just like killing me to go on the streets of DC, where it is a high drug usage area and speak French, if I am not allowed to talk the ways street kids accept and understand the way I talk, if I do not look like they look, if I am dressed in this suit, that will not make it.

So, what has worked is using peer-level education in all ranks and I will be very glad to give you some follow-up information in writing on what has worked and what has not worked. Let me tell you that we have seen some definite change in behavior. We first started and it was a joke to even try to give a young black youth a condom. We now distribute 1,000 condoms per night just in our little program.

What also works is the credibility and trust that you get if you continue to go back. Please let me say about finishing, that it is just not enough to provide the education, no matter how much you provide in education. We have to take the next step and help people learn how to change behavior and that is the tougher job.

Thank you.

Chairman GLENN. Thank you very much.

Mr. Coburn.

TESTIMONY OF JAY H.S. COBURN, DIRECTOR, SAFE CHOICES PROJECT, THE NATIONAL NETWORK OF RUNAWAY AND YOUTH SERVICES, WASHINGTON, DC [1]

Mr. COBURN. Chairman Glenn, my name is Jay Coburn and I direct the Safe Choices Project for the National Network of Runaway and Youth Services. I am here representing the National Network of Runaway and Youth Services and over 900 community based programs that serve the thousands of young people living without the support of our schools and other institutions. The National Network of Runaway and Youth Services educates and assists the Nation in providing support and services for high-risk youth and their families, so they may lead safe, healthy and productive lives.

Thank you for the opportunity to speak. I would like to briefly talk about why high-risk youth are at the greatest risk for HIV infection, describe our CDC-funded Safe Choices Project and discuss

[1] See p. 118 for Mr. Coburn's prepared statement.

what we have learned in working with CDC's Division of Adolescent and School Health on HIV prevention initiatives.

So, why are adolescents at the greatest risk? Adolescence is a time of experimentation for most young people, as they assert their independence from parental figures and begin to explore new ideas and behaviors in preparation for adulthood. Unfortunately, this experimentation includes early sexual activity and alcohol or drug use, placing youth at risk for a variety of health problems, including HIV.

Youth at highest risk for HIV infection face the same developmental challenges as other youth. They experiment, test limits and believe they are invulnerable. However, they are moving into adulthood without guidance. They are isolated from institutions such as families, schools and doctors that provide HIV prevention messages.

Runaway and homeless youth are particularly vulnerable. Life on the streets appears to be the most viable option for many of the estimated 1.3 million youth who have fallen through the cracks of an overburdened child welfare system or who have fled abusive families. These young people are black, brown and white, their families are affluent and poor, many have been abused and betrayed by adults. They are distrustful and have been emotionally battered.

In fact, 40 to 60 percent of these young people have been physically or sexually abused. They lack self-esteem and turn to drugs and alcohol to fit into the street scene and escape their pain and sense of hopelessness. Many are the survivors of sexual abuse. They have yet to learn the difference between intimacy and sexuality and engage in sex, when all they really want is someone to hold them and take away their hurt. Their lack of education makes survival sex or prostitution one of the few ways to earn a living.

Runaway and homeless youth often lack HIV prevention information, the negotiation skills necessary to practice safer behavior, and access to condoms or bleech to disinfect needles. Too often, depressed and demoralized, these youth lack the will to save their lives through less risky behavior.

Getting young people off the street is bottom-line HIV prevention. Also, street outreach and youth emergency shelter programs are the point of access for many of these high-risk young people. With resources and training, these community-based organizations are strategically poised to help young people change their behavior to make them safe from HIV infection.

So, what are we doing at the National Network to provide training and assistance to these community based organizations? Our Safe Choices Project has received funding from DASH for the last 3 years. The project's goal is to expand HIV prevention activities benefiting out-of-school youth. Working with community based groups nationwide, we provide educational materials, training and technical assistance and public information.

Our Safe Choices Guide is the central component of the project and is designed to help youth serving organizations develop HIV policies and staff and youth HIV prevention education programs. Final approval on the text of the guide was received from DASH on April 27, and the guide will be distributed free to over 340 feder-

ally-funded runaway and homeless youth centers and other youth serving agencies nationwide.

Workshops and training seminars are held throughout the country to alert youth workers to the impact of the epidemic on young people. So far this year, we have reached 400 youth workers, teachers and other professionals. By October 1, an additional 300 youth workers in each of the 10 Federal regions will have participated in our 2-day intensive training.

We also provide technical assistance and a toll-free hotline to provide assistance in developing programs and finding materials for professionals serving at-risk youth.

So, what have we learned from working with DASH on HIV prevention initiatives? Effective HIV prevention for all youth must provide information and skills. Teaching young people about how the virus impairs the immune system will not help them if their partners refuse to use a condom. Young people need refusal and negotiation skills and explicit information, if they are to reduce their risk.

A recent study found that at-risk youth lack negotiation skills and, despite a high level of knowledge about HIV infection, continue to engage in high-risk behaviors with multiple partners. Successful behavior change intervention requires 10 one-hour sessions, providing explicit information and skills training. Local communities need highly skilled trainers to work with these young people.

Numerous Federal agencies within the Public Health Service, including DASH, NIMH, and NIDA, fund agencies serving out-of-school youth. However, there is not enough coordination between agencies nor is there enough sharing of resources and model programs.

To address these difficulties, we recommend that more funds be made available directly to community based organizations, to provide young people with intensive training necessary to initiate and sustain behavior change, and to national organizations who can provide training and materials to local organizations.

We recommend that the CDC modify current restrictions on the content of HIV prevention messages, to be consistent with the Cranston Amendment allowing the use of targeted materials proven to be effective by public health experts, even though they may offend some audiences.

We also recommend that PHS increase coordination among Federal agencies making HIV prevention grants to community based organizations targeting out-of-school youth.

I would also like to comment on the placement of the out-of-school youth initiative at CDC. As you know, the initiative is now based within DASH. At first glance, the wisdom of making the departments of education responsible for students who appear to have left their system may seem questionable. However, practice yields other conclusions.

First of all, the boundary separating in-school and out-of-school youth are permeable. Youth may be in and out of school over periods of time, for a variety of reasons.

Second, schools know young people and the technologies that enhance their learning better than any other system. Young people

in trouble need to be served by systems tailored to meet their developmental needs.

Health departments, homeless shelters or drug treatment programs designed for adults are inappropriate for adolescents. Minors are often denied services at adult oriented programs and if they can be served, they are often exposed to the influence of very troubled adults.

Also, as schools respond to the crisis in education and train the workforce of the future, adolescents who have left school need encouragement and help in reconnecting with the school system. The DASH program reinforces this involvement.

Finally, DASH's initiative is resulting in some unique and effective partnerships between public agencies and community based organizations. Some examples of these collaborations include, in Senator Kohl's home State of Wisconsin, the Department of Public Instruction funded a training conference for runaway and homeless youth programs, using CDC funds and conducted by our staff.

We have provided technical assistance to 24 State teams of public and private agencies at three DASH-sponsored conferences for State education agencies. Next Sunday, Monday and Tuesday, in your home State of Ohio, we will be training 40 youth workers who will attend a 2-day training provided by our project. They will be joined by representatives of the Ohio Department of Education, the American Medical Association's DASH-funded Youth HIV Education Project, as well as a program officer from the AEtna Life & Casualty Foundation, who is interested in funding HIV prevention for high-risk youth.

However, these collaborative relationships need to be expanded and DASH should continue to require education agencies to work more closely with community-based youth-serving agencies. Some State education agencies still lack expertise for reaching out-of-school youth and DASH should use its six national organizations serving these youth, to provide technical assistance to education agencies.

We recommend that CDC's HIV prevention efforts targeted at out-of-school youth continue to be coordinated by DASH, that DASH should require education agencies to more aggressively work with community based agencies reaching out-of-school youth, and that DASH should increase funding for national organizations that work with constituencies serving out-of-school youth, enabling us to provide more comprehensive technical assistance to SEA's and LEA's. These ground-breaking partnerships will ultimately benefit out-of-school youth by teaching those who work with them how to provide HIV prevention and by teaching educators the needs of the out-of-school youth and how to best reach them.

Under DASH's and the Federal Government's leadership, communities are finally banding together to address the myriad of problems facing high-risk youth and their families. It is our recommendation, Senator Glenn, that DASH's efforts should be continued and strengthened. Thank you and we appreciate your leadership in drawing attention to this issue.

Chairman GLENN. Thank you all very much.

I have two pages of questions here that I am not going to be able to get to. What we will do is send some of these to each one of you

or maybe the whole works to all of you, I do not know. We will break it down somewhat, and we would ask that you respond for the record, please, because I do have to go to the floor. I have a commitment over there and I am sorry we do not have time for more questions this morning. If you would respond to these, we would appreciate it very much and your response will be included in the record as part of the hearing.

I am sorry I do not have time to stick around and talk with some of you a little bit more here this morning.

David, I wanted to talk with you in particular, a little bit about this, but I do have to go over to the floor.

Thank you all very much for being here this morning. The Committee will stand in recess, subject to call of the Chair.

[Whereupon, at 12:00 noon, the Committee was in recess, to reconvene subject to call of the Chair.]

APPENDIX

United States General Accounting Office

GAO Testimony

For Release
on Delivery
Expected at
9:30 a.m. EDT
Thursday
May 3, 1990

**AIDS EDUCATION:
Gaps in Coverage Still
Exist**

Statement of
Mark V. Nadel, Associate Director
for National and Public Health Issues
Human Resources Division

Before the
Senate Committee on Governmental
Affairs

SUMMARY

Most American teenagers have received essential information on the causes of AIDS and how to minimize the risks of becoming infected with HIV. However, GAO found that there still were gaps in the provision of AIDS education.

In reviewing the school-based HIV education program nationwide, GAO found that

-- Two-thirds of the nation's school districts offer HIV education;

-- smaller districts were less likely to provide HIV education;

-- HIV education is not provided at all levels, particularly in the upper grades, where the likelihood of sexual activity is greatest;

-- essential planning and monitoring data on students' knowledge, beliefs, and behaviors are inadequate; and

-- teacher training is often insufficient or lacking.

In reviewing education programs targeted at high-risk, out-of-school youth, GAO found that

-- CDC's Division of Adolescent and School Health has been slow to address HIV education needs;

-- the Division has primarily funded education agencies and the resulting out-of-school activities have been limited;

-- the Division plans a new initiative to fund health departments to reach out-of-school youth that potentially duplicates another CDC Center's approach.

Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss our review of education programs for youth designed to limit the spread of the human immunodeficiency virus (HIV), which causes acquired, immunodeficiency syndrome (AIDS). We focused our work on the lead federal effort--the HIV education program run by the Division of Adolescent and School Health (DASH), within the Centers for Disease Control (CDC). Without a human vaccine or cure available, education is the primary weapon against the profound medical and social costs of the HIV epidemic.

Most American teenagers have received essential information on the causes of AIDS and how to minimize the risks of becoming infected with HIV. However, there still are gaps in the provision of AIDS education. For example, AIDS education drops off sharply in the 11th and 12th grades, just as sexual activity tends to increase. In addition, students in smaller school districts are less likely to receive any AIDS education. Furthermore, AIDS education efforts are most clearly deficient where they are most clearly needed--in the high-risk out-of-school population, which includes runaway and homeless youth.

BACKGROUND

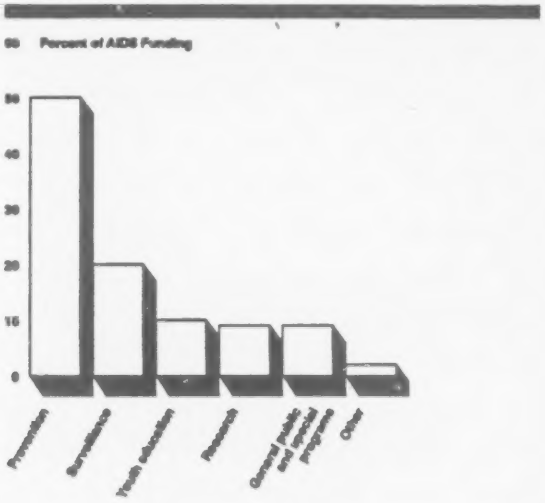
Many young people are engaging in sexual behaviors and drug use that place them at risk of HIV infection. Although few teenagers have AIDS, about 20 percent of people with AIDS are in their 20s. Because HIV's median incubation period is estimated at nearly 10 years, many of these people were infected with HIV while they were teenagers.

CDC has the lead responsibility for federal HIV education efforts. Its Center for Chronic Disease Prevention and Health Promotion, responsible for HIV education for school-age youth, initiated a nationwide HIV education program in late 1986. DASH, which is within this Center, provides technical and financial assistance through cooperative agreements to state and selected local education agencies and national organizations. These cooperative agreements are designed to help schools and agencies serving both in- and out-of-school youth develop HIV education programs. The education agencies and national organizations then design and operate their own programs.

CDC allocated $136 million of its fiscal year 1987 budget for all AIDS programs. Funding increased to about $438 million in fiscal year 1990. As shown in figure 1, about half of these funds were used for prevention activities, such as counseling and testing, health education and risk reduction, and minority initiatives,

which are administered by another CDC component, the Center for Prevention Services. About 10 percent of CDC's overall AIDS funding was targeted specifically for youth education activities in DASH.

CDC Funding of AIDS Programs
(FY 1990)



My testimony today will cover DASH's efforts targeted to both in-school youth and out-of-school youth, which includes runaways, the homeless, migrants, and incarcerated youth.

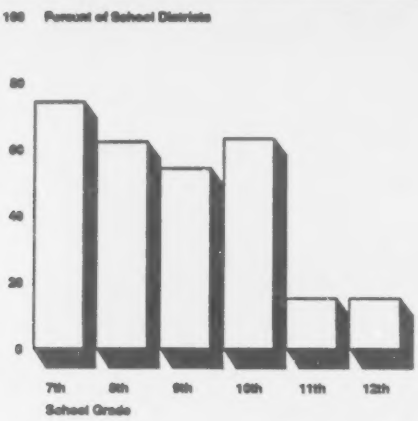
YOUTH IN PUBLIC SCHOOLS

First, I will discuss efforts to provide HIV education to students in public schools nationwide. HIV education in the school setting attempts to give students the knowledge and skills they need to avoid HIV infection. DASH focused on public school students because most youth are in rather than out of school. Also, it reasoned that HIV education provided in the school system could influence behavior before youth dropped out of school. Our information is based largely on a telephone survey of a nationally representative sample of school district officials.

HIV Education Is Not Provided
at All Grade Levels

CDC recommended that students at every grade level receive age-appropriate HIV education to expand and reinforce knowledge. However, only 5 percent of school districts required that HIV education be provided at every grade level. Coverage is most extensive in the middle grades and less so in the upper grades. As figure 2 shows, only 15 percent of school districts provided HIV education in the 11th and 12th grades. This is troublesome because sexual activity is likely to increase at these grade levels. School district officials told us that already crowded curricula restricted their ability to provide HIV education at every grade level.

Timing of HIV Education



Two-thirds of public school districts nationwide required that HIV education be provided at some point in grades 7 through 12 during the 1988-89 school year. Of the districts that did not require HIV education, most were small, enrolling fewer than 450 students.

Essential Planning and Monitoring Data Are Inadequate

For programs to set priorities, evaluate success, and improve operations, they must collect data on students' HIV knowledge, beliefs, and sexual and drug use behaviors.

However, over 80 percent of recipients of CDC funds did not collect this essential information. Only 11 percent of recipients met CDC standards for generalizable surveys dealing with students sexual and drug behaviors. CDC officials stated that essential information was not collected because this was the first program year for many states, and some lacked staff to conduct surveys. In some cases, recipients could not obtain state or local authorization to ask questions about students' sexual or drug use behavior.

Teacher Training Is Often Insufficient or Lacking

Training for some HIV teachers was absent or often insufficient. CDC has not set any standards for the amount of training required to effectively teach about HIV, but educational authorities with whom we consulted recommended at least 12 hours of HIV training. One-fifth of HIV teachers received no specialized training. The remainder received some training, but it was often less than 12

hours. That is, teachers in two-thirds of the districts received training of 10 hours or less, with a median of 7 hours. Most school district officials we talked to wanted to provide more training to their HIV teachers.

OUT-OF-SCHOOL YOUTH

Now I would like to turn to the status of HIV education for out-of-school youth. These youth are especially vulnerable to HIV infection because of the extraordinary stresses in their lives, their psychological problems, and the resulting high-risk sexual and drug behaviors they are more likely to engage in than other youth. Providing HIV education to these youth is difficult because they often are hard to locate and resistant to prevention messages. HIV education programs targeting out-of-school youth should provide information on HIV transmission and prevention and the skills to change high-risk behaviors. These programs are most effective when linked to others that provide for basic needs, such as food and shelter.

DASH Slow to Address Out-of-School Youth

DASH has been slow to address the HIV education needs of out-of-school youth. Cooperative agreements with education agencies generally included funding for both in- school and out-of-school

youth, but DASH initially targeted efforts to the larger, easier to reach, in-school population. DASH provided no specific guidance on how recipients should approach out-of-school youth. Nor did it specify what portion of any particular cooperative agreement was to be spent on out-of-school youth.

State and local education agencies, the primary recipients of DASH funding, are not geared to serving out-of-school youth. These agencies received awards averaging less than $300,000 to meet the needs of both in-school and out-of-school youth. Most of the funding was used for in-school programs. About 5 percent of the funds awarded to education departments were used to fund out-of-school youth programs. DASH also funded six national organizations to target their efforts to out-of-school youth. These organizations received about 5.6 percent of total DASH funds for youth education.

DASH-Funded Education for Out-of-School Youth Is Limited

DASH-funded HIV education efforts for out-of-school youth are limited. Few of the funded education departments targeted out-of-school youth for any HIV education services. Services needed, but usually not provided, included direct contact with out-of-school youth and design of appropriate HIV education materials or curricula. Recipients said this happened in part because they

lacked experience with these youth and the organizations that serve them. Moreover, those education departments that funded efforts outside the traditional school setting primarily targeted teenage parents or problem in-school youth, rather than homeless or runaway youth.

By Relying on Health Departments DASH Plans to Expand Program

Because these efforts did not effectively serve out-of-school youth, DASH plans to fund six local health departments or other local agencies to serve as focal points for adolescent education activities. These designated agencies will coordinate community HIV education efforts in high-incidence cities. Another center in CDC, however, has a similar effort underway to educate high-risk youth.

CDC's Center for Prevention Services
Also Funds Health Departments to
Target High-Risk Youth

The Center for Prevention Services also funds prevention programs in health departments and community-based organizations for populations at risk, including out-of-school youth. These include: (1) state and local health department prevention programs to support Health Education and Risk Reduction activities and special Minority Initiatives, (2) AIDS Community Demonstration

Projects to conduct research on community HIV education strategies, and (3) community-based organizations developing HIV prevention programs for minority and high-risk groups. We believe these programs potentially duplicate DASH's initiative to fund health departments to target out-of-school youth. Considering the urgent need to reach these high-risk youth, it may be preferable to concentrate efforts where the system is already in place to reach this high risk population, rather than waiting to develop a new initiative.

RECOMMENDATIONS

Concerning youth in public schools, we are recommending that the Secretary of Health and Human Services require the Centers for Disease Control to (1) take a leadership role in developing approaches to extend and reinforce HIV-related education for 11th- and 12th-grade students, (2) work with state education agencies to assist smaller school districts in overcoming resource or community barriers that prevent them from offering HIV education, (3) ensure that state and local grantees collect adequate survey data from students to evaluate and improve school-based programs, and (4) develop guidelines for the training of HIV teachers.

Concerning out-of-school youth, we are recommending that CDC consider whether the out-of-school youth component of DASH should

be merged with CDC's existing prevention programs within the Center for Prevention Services.

- - - -

This concludes my statement, Mr. Chairman. I would be happy to answer any questions you may have.

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

June 20, 1990

The Honorable John Glenn
Chairman, Committee on
Governmental Affairs
United States Senate

Dear Mr. Chairman:

These are our responses to the followup questions for the May 3, 1990 hearing posed in your May 24, 1990 letter.

Question

1. Should CDC officials make an effort to meet with the state or local authorities and parent groups which may be opposing the collection of this data, or would encouragement be better received if it came from an organization like the National Association of State Boards of Education (NASBE)?

Answer

We believe that CDC should use both approaches to encourage the collection of data on the knowledge, beliefs, and behaviors of students in order to allow adequate evaluation of HIV education programs. That is, CDC officials should make personal appeals to groups opposing such data collection while also enlisting the support of educational organizations to appeal to these same groups.

Question

2. What is your reaction to CDC's fear that setting a minimum standard for HIV teacher training becomes the maximum, and no additional instruction will then occur?

Answer

Our findings on the very low number of hours of teacher training provided indicate that some standard is necessary, even though it may be preliminary and require adjustment at a later date when CDC's research efforts provide new information. Given the large share of teachers with little or no training, it is important at this time to set a minimum standard to get the most essential information to all teachers dealing with AIDS.

Question

3. Do you believe that CDC should specify in the funding documents what portion of the funds should be spent on out-of-school youth?

Answer

We do not believe that CDC should require a specific percentage for out-of-school youth in funding documents. Rather, it would be preferable to encourage out-reach to this population and to fund organizations likely to serve them.

Question

4. Last summer, I received GAO's Report documenting staffing and funding problems at the Center for Prevention Services. Should we really be adding additional responsibilities concerning out-of-school youth to that Center when we already know there have been problems in its program for educating the general population?

Answer

CDC officials have informed us that past staffing shortages have been alleviated. In addition, we believe that out-of-school youth would be more quickly served by relying on the Center for Prevention Services that already has a system in place to serve these type of youth and has a much larger budget to do so.

Questions from Senator Sasser:

Question

1. Do you believe that rural school district officials have access to the latest facts and figures, which show that, in many states, including my home state of Tennessee, AIDS cases are rising most rapidly in rural areas?

Answer

While we have not interviewed rural school district officials about this specifically, it is quite possible that such officials may not have AIDS data for various reasons, either because they do not perceive a concern about HIV infection in their area or because health data are not easily accessible in their locations.

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Question

2. It is clear from your testimony that many small rural school districts do not require AIDS education. Do you believe that this may be in part to the perception, which is in my view inaccurate, that AIDS is a big-city problem, and not something that rural communities have to be concerned with?

Answer

We found that many small school districts do not require HIV education. Some of these district officials did say that such education was not perceived as immediately necessary in their locations. However, it is important for these communities to become concerned and initiate HIV education, as many of the teenagers from these areas will soon move to large urban areas where they will need the knowledge and skills to avoid HIV infection.

Sincerely yours,

Mark V. Nadel

Mark V. Nadel
Associate Director, National and
Public Health Issues

April 20, 1990

TO: Senator John Glenn
United States Senate
Committee on Governmental Affairs
Washington, D.C. 20510-6250

FROM: Ms Delores K. DuVall
Warren Easton Fundamental High School
3019 Canal Street
New Orleans, LA 70119

Dear Senator Glenn:

In response to your letter dated April 11, 1990, I am most happy to supply you with the information you have requested. I will try to be as thorough and concise as possible.

Here in New Orleans we try very hard to keep our teachers updated on information concerning HIV and AIDS. While the Centers for Disease Control has increased its funds for such education, I am disheartened that there is yet insufficient funds to reach all of the School-Aged Youths in our state. Because of the lack of funds, our schools cannot supply, what I feel, the necessary work-shops or materials needed to do the best job possible. I do want to give you some back-ground information on the Louisiana Educational System and then to share with you what we have tried to do in New Orleans. I will also then tell you what I do, under the circumstances, to reach students and the methods I use.

First, there are 28 Junior and Middle Schools and 24 Senior High Schools (Public). We are speaking of 33,000 students between the 7th and 10th grades. There are approximately 10,000 11th and 12th grade students. This is significant because the teaching of AIDS usually falls under the Physical Education and Health Department and our 11th and 12th grade students are not required to take Physical Education and Health. Our students are only required to take 2 years of Physical Education and Health and this is done usually in the 9th and 10th grades. Now if our 9th and 10th graders choose, in some schools, they may take ROTC. Subsequently, these students are lost to us. Thankfully, this is not a problem in my particular school. The State Law also prohibits the teaching of Sex Education below the 7th grade. This is certainly a law that need changing. We have found children that are sexually active long before they reach the 7th grade.

Before our teachers are permitted to teach Family Living and Sex Education, they must participate in a 5 day work-shop. There is also a Training In-Service held at Southern University of New Orleans in addition to the Health classes you must take in College. After you have met these qualifications, you go before a sub-committee to be approved in order to teach Sex Education. As a result of these requirements, 92% of our Physical

Education Teachers and 97% of our Adapted Physical Education Teachers are certified. For some reason, of which I am not sure, our better teachers seem to leave the classroom and move into Administration. Maybe this occurs because of the frustration of not being able to reach more students, and the poor salary teachers are paid in Louisiana. I, on the other hand, feel that I am desperately needed in the classroom. I feel my students truly need me and I love what I do. Here in New Orleans, we have what we call a STAT Program (students teaching AIDS to students. These students are Medical students from Tulane University and Louisiana State University). There are other organizations that we call on to help disiminate AIDS information, such as the American Red Cross, Planned Parenthood, School Nurses that are in attendance one-half day in every school, the National Clearing House for AIDS, the National PTA and the American Federation of Teachers.

Second, the teachers in New Orleans must be creative, knowledgeable, and love what they are doing. They must be willing to seek information and see that this information "hits home". The work-shops that have been available, and there have been six this school year, have not reached all of our teachers because they cannot be excused from their school to attend them. Maybe one teacher from each school will get to attend possibly four out of the six, if they are lucky. These work-shops are usually of a one day duration. Substitutes have to be obtained and paid . Considering the salary for the staff of these programs, money becomes a problem.

Thirdly, I would like to now tell you some of the things that I have done and am doing that has made made my program at Warren Easton such a success and it has been. I am also on the State Writeing Committee for AIDS. I use any method that I think may work. I have poster contests, these posters are then placed in every classroom, on the walls and in our Library. I flood our building with information. Last year my sex education class put on a play that was written and performed by my students. This presentation was delivered before the entire student body and videoed by our Video Club. This tape is in our Library and frequently used by our faculty to show to their classes. Students not attending Warren Easton at the time still have an opportunity to view this tape of our play. This has been so successful, other schools have borrowed our tape. This year my students put on a puppet show. The students had to write their own scripts and make their own puppets and then put on a presentation, of course information had to be correct. The faculty at Warren Easton then signed up to have the presentations presented to their classes. We used the best of these presentations. You would not believe the response from our teachers and students. What made this so meaningful was that now even our 11th and 12th graders got educated. I feel that I have, along with my Principle, done everything possible to see that the entire student body at Warren Easton is aware of the problem of AIDS and has knowledge as to how, by changing our behavior, we can make our lives better and safer. Our students are also being taught to understand and deal with compassion those suffering from this dreaded disease. My program works. Our students are knowledgeable, they know where to get information and they are able to pass on correct information. To be able

to eradicate misconceptions and wrong information must be the start if we are to prevent the spread of HIV and AIDS.

I am looking forward to our meeting and thanks again for this special opportunity.

Sincerely,

Delores K. DuVall
Teacher

Incl: List of Library Resource Materials
and Teacher Resources available to
the New Orleans Teachers

TESTIMONY

United States Senate Committee on

Governmental Affairs

May 3, 1990

Mr. Chairman and Members of the Committee:

I am Wanda Wigfall-Williams, Director of the National Initiative on AIDS and HIV Prevention Among Adolescents for the Center for Population Options, and I am pleased to represent CPO in discussing our efforts to prevent HIV infection and AIDS in school-aged youth. CPO's national initiative is funded, in part, by the Centers for Disease Control.

The AIDS and drug epidemics are gaining ground. Approximately 20% of reported AIDS cases are of people in their twenties. The long incubation period (up to 10 years) for the virus indicates that many of these people were probably infected with HIV during their teen years. Although adolescents make up less than one percent of the total number of AIDS cases, the Centers for Disease Control reported a dramatic 42% increase in the number of adolescents diagnosed with AIDS between July, 1988 and August 1989. Tragically, these statistics refer only to young people who have developed AIDS, not the unknown numbers of teens who are seropositive

and asymptomatic. Risk-taking behaviors (experimenting with drugs and engaging in unprotected intercourse) can result in deadly consequences. The need for HIV prevention and AIDS education is great. In our nation's capitol, one in 300 adolescents tested positive for HIV (Children's Hospital, 1988). Yet, focus groups with area teenagers conducted by the Center for Population Options (CPO) found that while teens are aware of HIV and AIDS, many do not perceive themselves at risk of becoming infected.

It is difficult to project the extent to which adolescents engage in activities that place them at risk for infection with HIV as well as other sexually transmitted diseases. However, teen pregnancy rates can serve as one measure of sexual activity -- one of the highest risk behaviors. Approximately 1 million teenage women become pregnant each year.

Parents, teachers, religious leaders, policy makers, health educators and youth have a responsibility to address this epidemic. The Center for Population Options has developed a comprehensive program focusing on reproductive health, health promotion and "life planning" for adolescents. In order to reach young people with motivating messages, practical information and accessible services, CPO:

* approaches young people from a diversity of concerns and perspectives with reality-based, simple messages;

- works through national, state and community-based organizations to reach the largest numbers of youth, particularly those at greatest risk;
- encourages multidimensional programs which provide formal and informal information and comprehensive health services;
- creates new programs if needed and evaluates existing ones to ensure that models are available to youth-serving professionals; and
- assists opinion makers to reinforce messages and policy makers to support programs which prevent infection with HIV and other sexually transmitted diseases.

Peer education can be a powerful approach to education for adolescents. Numerous studies have demonstrated that teens are more likely to ask their friends than an adult for information on a variety of topics, including health and sexuality. Often, peers are not only the main source of information for each other, they also are the most influential in their ability to shape others' behavior. The peer group is the primary reference for values and behaviors. In a focus group study conducted by CPO, inner-city adolescents said they would most likely listen to and believe what a person their age infected with HIV said about AIDS rather than what an older person or famous person said about AIDS or the virus. Further, an unpublished survey on condom use among adolescents found that teens' perceptions of other teens' condom use behaviors was the best indicator for determining their own condom use.

Educators have found that perceived similarities in age, interests and life experience between the influencer and the audience are critical determinants of the persuasiveness of the message and in the success of attitude and behavior change. Therefore, peer education has an automatic advantage over education provided by adult professionals.

Recognizing the power that teens have over one another, and that this power can be used to influence teens' behavior in a positive way, CPO developed **Teens for AIDS Prevention (TAP)** to educate adolescents about AIDS and HIV prevention. The TAP program provides 25 hours of skill-building training for a small group of peer leaders. Once the TAP members complete the training, they create and implement activities in their school or community that focus on:

* reducing misinformation
* explaining consequences of and alternatives to risky behaviors; and
* increasing sensitivity to HIV infection and AIDS, including personal vulnerability, and ways to protect oneself from HIV infection.

It takes time to increase knowledge and change behaviors. Research indicates that simple, straightforward and factual HIV prevention messages delivered consistently by numerous sources, including peer educators, have a positive effect on changing knowledge, attitudes and behavioral intent.

Today, I am accompanied by Brian Bess and Rahim Jones from Ballou High

School, located in Washington, D.C. As a result of their involvement in the TAP program in their school they have written a rap about HIV prevention and AIDS and will perform it for you now.

By Brian Bess, Ballou Senior High School

Acquired Immuno Deficiency Syndrome,
I'll tell you straight up people it hits home.
It hits you hard and soon you know you're done for,
No rejoicing or praying you know the score.
I mean you can have AIDS you say you doubt it,
You or you with AIDS think about it.
I wanna milk this subject like I would a cow,
No ignorance needed just listen now.
Can you catch the disease by just sharing hands,
from toilet seats, from meats, from touching no you can't.
You should know shooting up would do you harm,
Injecting dope and disease right up in your arm,
I mean I pack me a rubber like it's a lucky charm,
So put you sex in check or else Joe your gone.
Because it can't be contained it'll spread around,
You're the problem won't solve 'em let me break it down.

Human Immunodeficiency virus,
You have to take high like Osiris.
C.P.O. and we will educate thee,
On the do's and don'ts of A-I-D-S, I want to express,
The negative trip that's coming from the rest.
Who thinks a subject like AIDS is just a gay click,
You're disillusioned, you're being stereotypic.
The needle drug users, the over abusers,
Are subject to AIDS and the accusers.

Male or female, gay or straight,
The AIDS virus doesn't discriminate.
Quote unquote D.D.P. for a while,
You just can't trust a big butt and a smile.
Not to be contracted from a kiss or cold sore,
Not to be given through the sweat of your pores,
Now that you know the information the score,
And if you wish it I'll tell you more,
Because it KILLS.

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
Atlanta GA 30333

Testimony of

Gary R. Noble, M.D.

Assistant Surgeon General

Deputy Director (HIV)

Centers for Disease Control

Public Health Service

U.S. Department of Health and Human Services

on

AIDS EDUCATION FOR SCHOOL-AGED YOUTH

Before the

Committee on Governmental Affairs

U.S. Senate

May 3, 1990

Mr. Chairman and Members of the Committee, I am Dr. Gary Noble, Deputy Director of the Centers for Disease Control (CDC), with responsibility for its HIV Prevention Programs. I am pleased to have this opportunity to discuss CDC's efforts to help prevent HIV infection among school-aged youth. I am accompanied today by Virginia Bales, Deputy Director, Center for Chronic Disease Prevention and Health Promotion (CCDPHP), CDC, and by Dr. Lloyd Kolbe, Director, Division of Adolescent and School Health, who helps direct the CDC programs to prevent HIV infection among school and college-aged youth.

In October 1986, the Surgeon General of the United States called for schools to teach our Nation's youth about the risks of becoming infected with the human immunodeficiency virus (HIV). In that same month, CDC's program on School Health Education to Prevent the Spread of HIV Infection was initiated.

The primary purpose of CDC's program is to prevent HIV infection among youth. CDC's program is designed to build the capacity of schools, and other youth-serving organizations, to implement effective education about HIV that is consistent with community values and needs.

It is also designed to help integrate education about HIV within a more comprehensive school health education curriculum that provides a foundation for understanding the relationship between behavior and health, as called for by the Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic.

In 1987, CDC funded 15 State education agencies and 12 local education agencies in cities with the highest cumulative incidence of AIDS cases. The next year, CDC funded the remaining State education agencies, as well as four territorial education agencies, and an additional four cities.

I will now summarize some of the progress made by this program.

In 1986, with funding provided by CDC, the U.S. Conference of Mayors surveyed State education agencies to determine the extent to which they were assisting schools to implement HIV education for youth. Among the 25 State education agencies that responded to the survey:

-- Eight had curricula, recommendations, or teaching guides to assist local school districts.

-- One provided in-service training about AIDS for teachers.

Now, in 1990, only three years into CDC's program efforts, the State education agencies have developed the following program capabilities:

-- Every State education agency in the United States and in four territories has funding to help school districts implement HIV education.

-- Every State education agency has a well developed plan to help schools implement HIV education.

-- Every State education agency has dedicated and trained staff to help school districts implement HIV prevention programs.

-- Every State education agency is supported by a CDC staff member who is specifically assigned to assist the program manager on technical and programmatic issues.

-- Every State program manager has a strong working relationship with program managers from the 21 CDC-funded national organizations that are assisting State and local education agencies to implement HIV education for youth.

Today, State education agencies have the capacity to help schools implement HIV education.

I shall review what they are achieving.

State education agencies undertake four common activities: 1) policy development, 2) assistance with curricula, 3) assistance in implementing HIV education for out-of-school youth, and 4) conducting teacher training.

In <u>policy development</u>:

-- Between 1987 and 1989, the number of States, including the District of Columbia, that require HIV education in schools increased from 17 to 29.

— Of these 29 States, 12 require that HIV education be included in a comprehensive health education program, while 11 States require it as part of family life education, human growth and development, or sex education.

In assistance with curricula:

-- 90 percent of all States have developed curricula or curriculum guides for use by districts within the State.

In assistance in implementing HIV education for out-of-school youth:

-- 31 State education agencies are helping other agencies to educate out-of-school youth about HIV this year. In 1989, from the funding received by CDC, these States allocated a total of over $500,000 to support these activities.

-- Last year, States assisted almost 300 agencies (such as juvenile detention centers, neighborhood youth centers, and community recreation centers) to implement HIV education programs.

In conducting teacher training:

— All States now are providing HIV-related training to local school personnel.

-- During the 1988-89 school year, State education agencies conducted training programs that reached over 100,000 local school personnel.

These activities undertaken by State education agencies are designed to help local school districts implement HIV prevention programs.

I shall review the progress local school districts are making.

Based on the preliminary results from the survey conducted by the U.S. General Accounting Office in 1989, it was determined that:

-- 79 percent of the districts surveyed nationwide require HIV education in health classes.

-- 63 percent of the districts nationwide introduce HIV education before the 6th grade.

-- 74 percent of the districts are providing HIV education in the 7th grade.

The GAO also found:

-- 88 percent of the school districts nationwide provide in-service training to HIV education teachers.

-- 83 percent of teachers who instructed students about HIV had received HIV education training.

Clearly, the funded State and local education agencies, as well as local school districts across the country, are implementing education programs for youth that will help prevent the spread of HIV. CDC believes that its program on School Health Education to Prevent the Spread of HIV Infection has established a sound infrastructure for helping schools nationwide to implement HIV education curricula that are consistent with community values and needs. As this program continues, we hope to show continued progress.

However, much more remains to be done. Through grade 10, the majority of districts provide HIV prevention education in health education classes. By the eleventh and twelfth grades, the proportion drops dramatically because either health education is not provided, or it is offered as an elective. This is a significant gap in our Nation's ability to educate our youth to avoid preventable health problems. It is important that we recognize this gap and take appropriate actions to help schools overcome it. That is why CDC's program is emphasizing the implementation of organized, sequential, K-12 grade programs of comprehensive school health education that include HIV education.

We are very proud of the accomplishments of this program. We also recognize that we have much work ahead in helping State and local education agencies to implement effective programs.

I will now address, as requested, the specific issues raised by the Committee.

CDC PROGRAMS FOR SCHOOL-AGED YOUTH

The CDC's efforts to prevent HIV infection among youth are conducted through several program areas. CDC has established a multi-faceted program that combines the work of national health and education organizations, State and local education agencies, State and local health departments, numerous community-based organizations, and the national AIDS information program.

CDC's activities, by building the capacity of other organizations and by direct intervention, are designed to increase the number of youth who receive effective HIV prevention education.

PROGRAMS FOR YOUTH WHO ARE IN SCHOOL

CDC has been working to help schools provide comprehensive school health education since 1974 by helping to develop, evaluate, and disseminate effective health education curricula. In the late spring of 1986, to fill the gap in the Nation's HIV prevention strategy, CDC's core staff in school health education began planning a nationwide program to prevent HIV infection specifically among school-aged youth. In September 1987, with a budget of $11 million, CDC launched its program of School Health Education to Prevent the Spread of HIV Infection by providing fiscal and technical support to 15 national organizations, and to 15 State and 12 local departments of education that serve jurisdictions with the highest cumulative number of reported cases of AIDS. By the fall of 1988, with a budget of $30 million, CDC was providing fiscal and technical assistance to 19 national organizations, and every State, five territorial, and 16 local departments of education.

By fiscal year 1989, the budget had increased to over $35 million. Today, in fiscal year 1990, CDC has 45 staff and a budget of $45 million to help prevent HIV infection among school-aged youth. The request for fiscal year 1991, totaling over $52 million, will allow CDC to improve its assistance for in-school programs, as well as expand its efforts for out-of-school youth.

In planning the school health education program, CDC sponsored two national meetings in 1986 to identify needs associated with implementing HIV education for youth. Representatives from State and local education and health agencies and relevant national organizations identified the following needs related to implementing HIV prevention programs:

1. funding for program development;
2. national organization support;
3. HIV-related policies, guidelines, and recommendations;
4. teacher training programs;
5. access to educational resources;
6. parental involvement and support;
7. data describing HIV-related knowledge, beliefs, and behaviors among youth;
8. means to evaluate educational interventions.

The school health education program was designed to address these needs.

How CDC Administers the In-School Programs

The school health education program consists of six major elements that work together to prevent HIV infection and other important health problems among youth.

For the first element, CDC provides fiscal and technical support to more than 20 national organizations that can help schools and other youth-serving agencies to implement effective HIV education programs. Examples of these organizations include the National Association of State Boards of Education, the American Association of School Administrators, the National Congress of Parents and Teachers, the National Network of Runaway and Youth Shelters, the National Organization of Black County Officials.

The second element, as I have mentioned, consists of providing fiscal and technical support to 55 State and territorial departments of education, and to local departments of education in 16 cities with the highest cumulative incidence of AIDS, to help implement effective HIV education. These agencies develop and implement HIV education guidelines and policies, curricula, and teacher training workshops.

As part of the third element of the school health education program, CDC supports training workshops for program managers, including school decisionmakers, parents, and health department representatives, to help them in developing and implementing HIV prevention education programs within their jurisdictions.

Fourth, CDC has established a materials development and information dissemination system to assure that HIV education material for youth are scientifically accurate and widely available.

Fifth, CDC has established a youth risk behavior surveillance system to assess whether risk behaviors that result in HIV infection, and other important health problems, increase, decrease, or remain the same over time. This system provides national, State, and local data.

Through the sixth and final element, CDC helps States and cities evaluate their programs and interventions, and conducts evaluation research that will assess the extent to which HIV education interventions for youth are effective. The research findings consequently should allow us to improve the effectiveness of HIV educational interventions.

Managing the Cooperative Agreements With State and Local Education Agencies

CDC provides funding to every State and 16 local education agencies to help schools implement HIV prevention education that is consistent with community values and needs. In doing so, these agencies conduct core activities such as: assisting school districts in establishing advisory committees to select HIV prevention education materials; training teachers to use the locally-selected or locally-developed HIV education materials; providing local communities with periodic information about HIV-related knowledge, beliefs and behaviors among high school students; and evaluating and improving their HIV education programs.

The financial and technical assistance that CDC provides to the State and local education agencies is guided by a cooperative agreement between CDC and each funded agency. CDC requests each year that the State and local education agencies develop four objectives to assure that school-aged youth receive HIV education:

1. increase the number of junior and senior high schools that provide HIV education;
2. increase the number and percentage of junior and senior high school students at each grade level who receive HIV education;
3. increase the number of junior and senior high schools that integrate HIV education within a more comprehensive school health program;
4. increase the number of other agencies that implement HIV education for high-risk youth, minority youth, out-of-school youth, and youth with special education needs.

CDC also requests that funded State and local education agencies collect data on an annual basis to measure their progress in meeting each of the four objectives described above. CDC provides fiscal and technical assistance to all funded State and local agencies to help them conduct these assessments. This technical assistance is provided through site visits, workshops, phone consultations, and the distribution of a survey handbook that contains sample survey instruments and guidelines for data collection and analysis.

CDC has not received reports that funded education agencies, for their in-school programs, have experienced problems with the current restrictions on the content of HIV education materials as described in the document entitled:

Content of AIDS-Related Written Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments, and Educational Sessions in Centers for Disease Control Assistance Programs, which was published by CDC in October 1988.

However, because local communities appropriately have the authority and responsibility to determine the content of HIV education for students, some communities restrict what can be discussed in their schools.

Training of HIV Educators

Part of the funds provided to State and local education agencies is to be used to train teachers to use HIV prevention education materials. CDC's Guidelines for Effective School Health Education to Prevent the Spread of HIV, published in January 1988 after more than a year of development, recommend that initial and continuing in-service and pre-service training be provided to staff members who will be teaching HIV prevention education. The amount of time for this training is not specified. CDC has been concerned that any recommended standard will be misconstrued as the maximum amount of training needed to effectively provide HIV education.

However, with support from CDC, several national organizations have developed teacher training guides. For example, the National Education Association (NEA) developed a manual for teacher trainers to assist in planning and conducting 12-hour training workshops for teachers and other school staff. The training consists of three modules that were developed in response to a needs assessment conducted by NEA:

1. Module One includes basic information about HIV and AIDS and is designed to help school personnel respond to questions.
2. Module Two addresses school policies related to HIV and the importance of implementing such policies.
3. Module Three provides concrete assistance in selecting or improving HIV prevention curricula.

Also with support from CDC, the Education Development Center (EDC) developed and distributed "HIV Education In The Classroom," a guide to help trainers prepare teachers to teach about HIV in the context of comprehensive school health education. The guide includes specific sections for Kindergarten through third grade teachers, fourth through sixth grade teachers, middle school teachers, and junior and senior high school teachers. The guide addresses:

-- providing accurate, up-to-date information about the HIV epidemic;
-- presenting HIV education that is appropriate for the developmental levels of students;
-- introducing HIV education activities by modeling and practicing classroom sessions;
-- preparing teachers to respond to students' issues and concerns.

In addition, with support from CDC, Education Training Research, Associates (ETR) developed 4 training programs for teachers and other school personnel. Each 12 to 18 hour program provides school personnel with knowledge and skills needed to teach HIV education.

It is important to remember that State and local education agencies began their HIV prevention programs only a short while ago. At the time of the GAO survey of school districts regarding HIV education for school students, more than 60 percent of the State and local departments of education had received financial and technical support from CDC for nine months. We were pleased with the GAO finding that 80 percent of those teaching about HIV had received training about HIV at the time the study was conducted. As CDC staff were quoted in the GAO report, we feel that much has been accomplished, but much more remains to be done.

Why HIV Prevention Education is Important for In-School Youth

CDC is concerned about the extent to which teenagers and young adults are at risk for HIV infection. We know that one out of every five persons reported with AIDS in the U.S. was between 20 and 29 years of age at the time of diagnosis. Since the incubation period between HIV infection and AIDS diagnosis can be ten years or more, then some proportion of those diagnosed with AIDS, ages 20-29, were infected as teenagers.

We know that the sexual behaviors that may result in HIV infection among teenagers also result in about 2.5 million cases of sexually transmitted diseases and 800,000 unintended pregnancies among teenagers every year. And we know that the behavioral patterns that result in HIV infection, sexually transmitted diseases, unintended pregnancies, alcohol and drug abuse, and other important health problems often are inter-related and often are established during adolescence. Thus, this is a critical population to target if we are to improve the health of the Nation.

We think that educational programs to prevent HIV infection and other important health problems can be most effective when they are implemented as part of a planned and sequential, kindergarten through grade twelve, program of comprehensive school health education. Such a program establishes a foundation of basic health knowledge that helps young people progressively establish the skills they will need to avoid a range of inter-related health behaviors and health problems.

The Nation's schools provide an existing and efficient system to reach almost all young people during the ages when they are most impressionable, and to reach many young people who may ultimately drop out of school. That is one reason why CDC has invested in helping the Nation's schools to provide effective HIV education. We need to remember that out-of-school youth were at one time in a school environment.

PROGRAMS FOR YOUTH WHO ARE NOT IN SCHOOL

Efforts to provide HIV prevention education for out-of-school youth require a coordinated and complementary approach that takes advantage of the unique expertise found among several CDC program areas. The CDC's Office of the Deputy Director (HIV) directs the HIV prevention programs throughout CDC, including those that work with out-of-school youth. The Office is the locus for the prevention efforts for this population, coordinating the work of the Center for Chronic Disease Prevention and Health Promotion, the Center for Prevention Services, and the Center for Infectious Diseases.

About nine million youth, aged 14-21, do not attend school or college and may be at greater risk for HIV infection than their peers who do. Out-of-school youth at the highest risk for HIV infection include: school dropouts, youth in juvenile justice facilities, runaway and homeless youth, young prostitutes, youth in gangs, and youth in substance abuse or mental health programs. However, because these high-risk youth may be found in a variety of settings and environments, and are not usually part of an organized system where they have ready access to HIV prevention education, they are much more difficult to reach than the in-school population. To reach these youth effectively, a variety of activities from several program areas are necessary.

Activities of the Center for Chronic Disease Prevention and Health Promotion

The CDC's Center for Chronic Disease Prevention and Health Promotion uses the elements of the program on school health education described previously to also build the capacities of agencies that work with out-of-school youth to implement HIV prevention education programs for these youth. For example, five national organizations that receive funding from CDC develop and implement educational programs for out-of-school youth, and provide training to staff who work in agencies that serve out-of-school youth. One organization, the National Network of Runaway and Youth Services, has developed a guide for those who will provide HIV education for out-of-school youth.

In addition, over 75 percent of the funded State and local departments of education are carrying out activities to assist agencies that serve out-of-school youth in their jurisdictions to implement HIV prevention

education for this population. Many of the departments of education provide financial and technical assistance to local agencies that serve out-of-school youth. As an example, one local department has conducted a workshop on HIV education for local agencies, developed an HIV self-study unit for out-of-school youth, and identified HIV education resources for local agencies that serve these youth.

Finally, a training and demonstration center in San Francisco has conducted twelve training and demonstration programs for over 400 staff serving out-of-school youth from 35 States and 74 cities.

Activities of the Center for Prevention Services

The CDC's Center for Prevention Services has cooperative agreements with State and local health departments, with minority and other community-based organizations, and with the United States Conference of Mayors, to conduct HIV prevention programs. The State and local health departments, through the fiscal year 1989 HIV Prevention and Surveillance Cooperative Agreements, provided support to 54 community-based organizations that, as part of their target audience, serve youth, including out-of-school youth. These organizations conduct a variety of prevention activities, including outreach programs to homeless youth, risk reduction education, referral to HIV counseling and testing, and if appropriate, referral to drug treatment programs, and other medical/social services. Many of these programs are targeted toward racial/ethnic minority youth.

As part of the fiscal year 1989 HIV Prevention Cooperative Agreements with minority and other community-based organizations, CDC directly supported 24 community-based organizations that, as part of their target population, serve youth. These organizations also provide a variety of prevention activities, similar to those mentioned above.

Finally, in 1989, the United States Conference of Mayors awarded approximately $373,000 to nine community-based organizations serving youth.

Activities of the Center for Infectious Diseases

The CDC's Center for Infectious Diseases, whose activities are focused on surveillance, laboratory and epidemiologic investigations, conducts a variety of HIV surveillance studies, some of which assess the prevalence of HIV infection and associated risk behaviors in out-of-school youth. In collaboration with State and local health departments, CDC currently conducts blinded HIV serosurveys (unlinked to any identifiable individuals) in homeless populations, including youth, in eleven cities throughout the country. Other surveys that include homeless youth in the populations that are accessed are conducted in sexually transmitted disease (STD) clinics, drug treatment centers, women's health clinics, and tuberculosis clinics in over 40 metropolitan areas. From 1988 to 1990, demographic data and risk exposure information, as well as seroprevalence data, have been collected on over 110,000 clients, ages 15-24. For example, among youth 15 to 19 years of age seen at the participating STD clinics, the HIV seroprevalence ranges from 0 to 4.6 percent, with a median of 0.5 percent.

Other surveys measure HIV prevalence in groups that include youth, but generally cannot distinguish those youth who are out of school or homeless. These include surveys among childbearing women in 46 States and territories, among patients in a network of 40 hospitals, college student clinics, and prisons. In addition, CDC works with other agencies to analyze results of their routine HIV testing, including the American Red Cross and other blood collection agencies, the Department of Defense, and the Department of Labor. Behavioral risks also are assessed among infected blood donors, while CDC is establishing studies with the Job Corps to assess HIV behavioral risks for infected and uninfected youth.

Fiscal Year 1991 Proposal for Coordinating Out-of-School Youth Programs

In fiscal year 1991, CDC is planning to help local health departments in 3-6 cities with the highest numbers of AIDS cases build coalitions of local governmental and nongovernmental agencies that serve out-of-school youth, and to consequently build more effective and coordinated HIV prevention programs for these youth.

In addition, funding will be increased for support of relevant community-based organizations in these high incidence cities to develop and evaluate intensive HIV prevention programs for out-of-school youth. Seroprevalence and behavioral research among this population will also be expanded.

NATIONAL AIDS INFORMATION PROGRAM

As a complement to the HIV prevention programs for school-aged youth described previously, CDC developed the parents and youth national public information program. The program, launched in May 1989, was the fourth phase of CDC's national AIDS information program. This phase was designed to alert all parents and youth to the vulnerability of adolescents and teenagers to HIV infection if they engage in high risk behavior. The national effort informed parents and other youth-serving adults of the behaviors that place persons at risk of HIV infection, and steps that can be taken to eliminate or reduce such risks. For the program, broadcast and print materials were developed and distributed, as well as an AIDS prevention guide to be used to foster HIV prevention discussions between adults and youth.

In 1986, CDC began its program to stimulate health education for children in this country with a small staff of four and a budget of $250,000. In 1990, the program consists of 45 staff and a budget of $45 million. These resources have enabled every State and several major cities to have the capacity to put in place programs to prevent HIV infection among school-aged youth. Through activities such as planning programs, developing policies, and training teachers, these State and local efforts will help prevent a new generation of AIDS cases.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
Atlanta GA 30333

JUL 27 1990

The Honorable John Glenn
United States Senate
Washington, D.C. 20510-6250

Dear Senator Glenn:

Thank you for your letter regarding HIV education for school-aged youth. Enclosed is the Centers for Disease Control's response to the questions that you and Senator Sasser posed.

Thank you for the opportunity to respond to these important questions. A copy of this correspondence is being provided to Senator Sasser.

Sincerely,

William L. Roper

William L. Roper, M.D., M.P.H.
Director

Enclosure

CDC Responses to Questions from Senators Glenn and Sasser

Senator Glenn's Questions

1. In response to one of GAO's recommendations, have you analyzed whether your new initiative to fund health departments to reach out-of-school youth duplicates the programs already funded by the Center for Prevention Services?

The new initiative to reach out-of-school, high-risk, and minority youth does not duplicate programs already funded by the Center for Prevention Services.

The Center for Prevention Services currently provides funding to health departments and other organizations for outreach and direct delivery of educational services to out-of-school youth by agencies serving these populations at the local level. Because such organizations have limited access to and time with out-of-school, high-risk, and minority youth, a large number of agencies throughout each community must be capable of providing such services if HIV education efforts for these youth are to be effective.

The new initiative will help local health departments in cities with the highest cumulative incidence of reported cases of AIDS to work with community agencies that serve out-of-school, high-risk, and minority youth to increase, focus, institutionalize, and coordinate efforts to address the multiple needs of these youth. This initiative will enable local organizations to provide a broad range of services and to keep these youth from "falling through the cracks" when referred from one agency to another.

As part of this new initiative, the local health department will establish and maintain a coalition of private and public health, education, and social service agencies to plan and coordinate the delivery of HIV education, and other important education and health services, for out-of-school, high-risk, and minority youth in cities with a high incidence of reported AIDS cases. Each coalition will identify local community agencies that serve these youth; assess the capabilities, efforts, and needs of these agencies; plan and coordinate activities to build their capacities to deliver effective HIV education and other needed health and social services; and annually collect data to describe the size, characteristics, accessibility, behaviors, and priority needs of these youth.

The local health departments will maintain a steering committee composed of agencies serving in the coalition to participate in all phases of program planning, implementation, and evaluation. Health departments will provide technical assistance and training to community agencies in implementing and improving policies and educational efforts, and will thus increase the availability and accessibility of resources and services.

This new initiative will build a stable infrastructure for the provision of effective education and health services to out-of-school, high-risk, and minority youth in cities with a high incidence of reported AIDS cases.

2. Some of the national organizations find that there are so many CDC reviewers of their proposed educational materials that they are forever editing and waiting for final approval. What is CDC doing to speed up this process?

In fiscal year 1990, CDC will work more closely with national organizations throughout the materials development process in order to provide effective and efficient technical assistance. Our goal is to review and return specific comments within 12 weeks of receiving final drafts. This timeframe may vary depending on the length and complexity of the material submitted.

CDC serves as a reviewer for all national organizations that develop HIV-related materials for youth as part of their cooperative agreement program and to all other national organizations that request assistance. This includes all HIV-related materials, such as curricula, guidelines, booklets, training manuals, etc., that are developed by national organizations for national dissemination. The reviews are undertaken by CDC to assure accuracy of scientific information, educational quality, and sensitivity to complex issues. Unlike State and local education agencies that can rely on their health departments for such review, national organizations have no similar sources of assistance.

CDC undertakes the review of these materials by obtaining written comments and recommendations from each relevant center within CDC. A complete professional copy edit of each document is also conducted. Written comments and recommendations made by CDC are then returned to the national organization. Final decisions on changes are the responsibility of the national organization.

3. As you know, only 30 States and the District of Columbia now require HIV education as part of the formal curriculum. Have CDC officials made any effort, or are you now contemplating any effort, to meet with the Nation's governors and legislators about your recommendations to have HIV as part of the formal curriculum?

CDC already supports efforts to help the nation's governors and legislators learn about the importance of HIV education as part of a more comprehensive program of school health education.

CDC provides financial and technical support to two national organizations that represent State-level policymakers who have primary responsibility for education in each State: the National Association of State Boards of Education (NASBE) and the Council of Chief State School Officers (CCSSO). NASBE represents members of State boards of education. CCSSO represents the chief State school officer in each State.

CDC supports NASBE's work with the National Conference of State Legislators to develop legislative support for HIV education and comprehensive school health education by linking State legislative committees responsible for health, human services, and education.

In the coming year, CDC plans include supporting NASBE to work with the National Governor's Association to promote HIV education in schools and as part of a more comprehensive program of school health education.

Each year, CCSSO and NASBE collaborate on a survey of actions taken in each State that promote HIV education. The results of this survey are distributed to legislators and other policymakers in each State and throughout the Nation.

Many HIV education coordinators employed by State education agencies work with their governors and State legislators to prepare legislation designed to help schools provide HIV education.

4. Is CDC aware of the situation in privately-funded military academies, parochial and private schools? How well are they incorporating AIDS education in their curricula?

Although CDC does not monitor the extent to which private schools incorporate HIV education in their curricula, CDC includes private schools in national surveys of student knowledge, beliefs, and behaviors. CDC-funded State and local departments of education help private schools in their efforts to provide HIV education. For example, the California State Department of Education pays for substitute teachers so that teachers from private schools can attend teacher training sessions conducted by the State department of education. The New York State Department of Education distributes its kindergarten through 12th grade HIV education curriculum guide to all private schools in the State. The Maryland State Department of Education provides technical assistance in the development of HIV education materials by the Archdiocese of Baltimore.

In addition, CDC provided scientific and technical support to the National Catholic Education Association as it developed an HIV education curriculum titled AIDS: A Catholic Educational Approach.

5. What is occurring on the college campuses? Are those institutions providing AIDS education to their students?

The extent to which colleges and universities nationwide are providing HIV education for students is not known. This year CDC will fund a lead university in-States with a high cumulative incidence of reported AIDS cases to: (1) assess the extent to which colleges and universities provide HIV education in the State, and (2) help increase the number of colleges and universities providing HIV education for students and faculty.

CDC efforts to help universities implement HIV prevention programs include the following:

- During fiscal year 1987, CDC began providing cooperative agreement funds to the American College Health Association (ACHA) to provide training to help students, faculty, and college ministry representatives design and implement effective campus-based HIV education programs. To date, 1,461 participants from 797 colleges and universities have received training through ACHA workshops.

  ACHA workshops address the development and marketing of campus-based HIV prevention programs, the initiation of peer education programs, and implementation of HIV-related counseling programs for students. Upon completion of the workshop, participants develop an action plan to be used in the implementation of an effective program once they return to their respective schools.

- Because many historically black colleges and universities are not part of the ACHA network, during fiscal year 1988 CDC awarded a grant to the National Association for Equal Opportunity in Higher Education (NAFEO) to provide HIV prevention education to students at 117 historically black colleges and universities. During the first year of the program, each member college and university president appointed one person to be responsible for coordinating HIV education programs on campus. During fiscal year 1988, 72 percent of the historically black colleges and universities participated in a satellite teleconference that served as the inaugural activity for this program, and representatives from 98 schools participated in training sessions conducted by NAFEO. Additionally, each of the 117 historically black colleges and universities received a videotape of the satellite presentation.

Senator Sasser's Questions

1. One of the more troubling aspects of the GAO report relates to out-of-school youth which have to this point been essentially left out of CDC's AIDS education efforts. Is CDC in a position to make available to education agencies guidelines or targeted educational materials which they can use to reach out-of-school youths?

Out-of-school youth have not been left out of CDC's HIV education efforts. CDC is currently using a multi-center approach to prevent HIV infection among out-of-school youth. Through this approach CDC:

- Provides financial and technical support to six national organizations that develop and implement educational programs and materials for out-of-school youth and provide training to staff who work in agencies that serve out-of-school youth.

- Assists more than 75 percent of State and local departments of education in providing financial and/or technical assistance to State and community agencies to assist them in educating out-of-school youth about HIV.

- Has supported 12 training and demonstration programs since 1987 that have provided training to over 400 staff members that serve out-of-school youth from 35 States and 74 cities.

- Provides financial and technical support to State and local health agencies and 54 community-based organizations (CBO) that serve out-of-school youth. In many States and cities, counseling and HIV-antibody testing services are provided through these agencies and other CBOs funded by the health departments.

- Conducts limited seroprevalence and behavioral research to assess the prevalence of HIV infection and associated risk behaviors in out-of-school youth.

- Carries out national public information program activities designed to reach these youth through the National AIDS Information and Education Program.

Senator Sasser's Questions
Question 1 continued

Guidelines have been developed and distributed specifically for out-of-school youth. Curricula and classroom support materials designed exclusively for this population have also been developed. These include the following:

- In 1988, CDC began to collaborate with the National Network of Runaway and Youth Services on the development of its Safer Choices Guide: AIDS & HIV Policies and Prevention Programs for High Risk Youth. This guide is now complete and CDC provides funding to the National Network of Runaway and Youth Services to help organizations that serve high-risk youth use the guide in teaching high-risk youth about the prevention of HIV infection.

- In 1988, CDC developed Guidelines for Effective School Health Education to Prevent the Spread of AIDS. The guidelines were developed to help school personnel and others plan, implement, and evaluate HIV education programs for youth in and out of school.

- In 1987, CDC initiated the AIDS School Health Education Database. This database provides information to educators throughout the Nation about the availability of video cassettes, comic books, curricula, and other materials designed to educate in and out of school youth about HIV.

2. As Chairman of the Senate Budget Committee, I am curious about your spending level. Have you found that your efforts are hampered by low funding levels? How much more in the way of funding is needed to adequately meet the challenge of AIDS education for school-aged youth, and how would any additional funds appropriated toward this effort be spent?

The President's budget request for fiscal year 1991 of over $52 million for HIV education for school and college-aged youth will allow CDC to continue building the capacities of State and local departments of education to implement HIV education programs. Both the Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic and CDC's Guidelines for Effective School Health Education to Prevent the Spread of AIDS call for the implementation of HIV education as part of a comprehensive school health education curricula. The Presidential Commission on the HIV Epidemic recommended that "All schools, both public and private, should have comprehensive health education programs for grades K-12 fully implemented by the Year 2000." Such programs establish a foundation for understanding the relationship between personal behavior and health in an organized, sequential, and developmentally appropriate manner from kindergarten through 12th grades.

Implementation and maintainance of effective and high quality comprehensive school health education programs in all schools will continue to require substantial time and resources at Federal, State, and local levels. Additional funding for CDC's ongoing school health education program could be used to assist selected States and cities implement other comprehensive school health education programs.

The President's request for fiscal year 1991 includes over $5 million for funding an out-of-school youth initiative that will allow CDC to help develop, coordinate, and implement HIV prevention programs for these youth in three to six cities. Any increase in funding could be used to expand such efforts to more cities with a high number of reported AIDS cases.

Testimony of

Patricia J. Brownlee
AIDS Education Facilitator
Baltimore City Public Schools

Before

Committee on Governmental Affairs
U.S. Senate

Hon. John Glenn, Chairman

May 3, 1990

Mr. Chairman, thank you for the opportunity to testify today as part of the Committee's hearings on HIV prevention education serving in and out of school youth. My name is Patricia J. Brownlee and I am the AIDS Education Facilitator for the Baltimore City Public School System in Baltimore, Maryland. You have asked that I address the following topics:

-What is Baltimore City Public Schools doing to relay the HIV prevention message to in school and out of school youth?

-What methods have been successful to this end? Why?

-What methods have not been successful? Why?

-What else can be done by federal, state and local governments to better educate our youth to prevent HIV infection and AIDS?

-What else can be done by federal, state and local governments to train our teachers to prevent HIV infection and AIDS?

-How well is CDC running HIV prevention programs for school-aged youth?

Baltimore City Public Schools receives funding for AIDS/HIV education through a cooperative agreement with the Center For Disease Control-Division of Adolescent and School Health (CDC-DASH). Requests for this funding have been made annually since 1987.

Following is a brief description of the AIDS/HIV education in Baltimore City Public Schools (BCPS):

With the funding support from CDC-DASH, a specific AIDS/HIV prevention curriculum consisting of three lessons at each level, in grades 3-12, has been integrated into a comprehensive health education program. Baltimore City Public Schools has been able to initiate and maintain a model AIDS/HIV education program, impacting nearly all of the 108,000 students enrolled. Communicable disease prevention is taught in kindergarten through grade 2 with AIDS/HIV infection presented as part of the larger body of communicable diseases. The curriculum format consists, of presentation of facts, attitude assessments and models for behavior change and prevention.

Empowerment strategies are reinforced to raise the self-efficacy of students to make positive health choices, not only in the area of STDs and substance abuse but in facets of their lives. The construction, writing, and printing of the curriculum was supported by CDC-DASH funding.

To assure and reinforce the success of the AIDS/HIV curriculum, extensive teacher training has been provided, through inservice workshops and college courses. Funding for substitutes to promote teacher attendance at workshops and stipends to defray tuition costs have been provided to teachers through CDC-DASH funding.

Teachers of special education and high-risk youth have been especially targeted for training. These teachers deal with students who are more likely to drop out of school and/or practice risk behaviors for contracting HIV infection. These teachers receive the most training because they deal with this population.

Cross-discipline training has been provided to teachers in other subject areas for understanding of the issues surrounding AIDS/HIV infection. Awareness training has been accomplished for all Baltimore City employees as mandated by Mayor Kurt Schmoke. This training was facilitated by BCPS teachers and personnel from other city agencies (e.g. health department) as a collaborative effort and impacted approximately 10,000 employees.

Attendance at conferences where the latest information is exchanged, field trips to health exhibits and facilities for teachers and students, quest speakers, contests to heighten awareness and special in-school presentations have all been possible through grant funding.

Support and supplemental materials, videos, pamphlets and updates have been provided to teachers responsible for AIDS prevention education. These various materials are on-site in each of our 180 schools offering maximum accessibility and motivation for use. The lessons in the curriculum provide for specific use of these A-V supports.

Numerous parent and community group presentations have been made to raise the awareness of the surrounding communities. Through heighten parent awareness, in school youth and out of school youth are reached. Follow-up presentations are encouraged.

BCPS cooperates with many other agencies, private and public, in Baltimore City to further the cause of AIDS/HIV prevention. Many of these agencies service out of school youth and young adults.

Reaching out of school youth with HIV prevention messages is a more complex undertaking and requires creative techniques for facilitation. With support from CDC-DASH, several programs have been initiated in Baltimore City.

Five BCPS teachers serve as outreach workers at The Francis Scott Key Medical Center Adolescent Detoxification Unit to deliver HIV prevention messages as well as safer sex and other health information to the young patients. These teachers average between 20 and 22 hours per week of instruction.

A unique project has been initiated in the community of Cherry Hill a subdivision of Baltimore City. Through collaborative effort between the American Federation of Teachers, also funded by CDC-DASH and BCPS, three outreach teams, consisting of one teacher and one paraprofessional, have been formed and trained to present HIV prevention messages to parent, church and other interested groups. This project has been so successful, that it will be expanded to other high risk areas in Baltimore City using Cherry Hill as a model.

A pilot peer education program utilizing 10 students from a Baltimore City Health Department "at-risk" youth education group was successfully initiated during the summer of 1989. The participants were trained in communication skills, HIV prevention education, STD prevention self-esteem, decision making, empowerment skills, and refusal techniques. As peer educators, these students made presentations at 27 sites (libraries, recreation centers, etc.) to well over 800 in and out-of school youth. This program will operate once more this summer using the same peer educators as trainers for new peer educators. This program will also be expanded to service in-school youth in middle school September 1990. Not only will the message be presented to peers, the peer educators will be impacted by the esteem building practices taught also.

Reaching out of school youth is difficult and more costly than reaching the larger population of in-school youth. For example, the Francis Scott Key Program will cost approximately $20,000 this year to service about 250 youth. (This is 9% of my total budget to reach a relatively small number of youth).

The AIDS/HIV education program in BCPS has been successful for several reasons. The messages begin early and are repeated consistently through all grade levels. As with any information and skill, the more it is repeated the more we tend to make it an automatic part of our behavior. If we consistently teach self-esteem building and self-concept raising techniques, our students will be in a better position to make positive choices in health as well as in all aspects of their lives. Every child is lovable, capable and of infinite worth. It is essential that every child believes this about himself. A comprehensive health curriculum in all grades emphasizing consistent message of positive self-worth will make a successful, healthy individual who will function well in society.

We can present facts and figures to our youth and ask them to recite on command this knowledge. This will not guarantee a healthy decision based on knowledge from that same youth. Most young people do not use their knowledge base to make decisions concerning sexual behavior. It is exceedingly important to teach our young people skills that they can put into action when faced with a compromising situation where a decision must be made. Practice of these skills through role play and peer teaching is essential to success. In BCPS comprehensive health curriculum, refusal skills, decision making and empowerment skills are taught, practiced and reinforced throughout.

Giving a definite message about abstinence from risk behaviors is very important. Peer pressure is extremely strong in adolescence. Teenagers, however, consistently name adults as those from whom they wish to receive information. Therefore, as adults, we must be consistent and definitive in our messages about abstinence. These messages must be age appropriate and clear. An unclear message gives no direction and the youth will follow peers which may or may not be the healthiest path.

A one time HIV prevention presentation for students is not satisfactory. Students need consistant, repeated messages about HIV prevention. These messages need to build decision making skills and refusal techniques. Informing students about the action of a retrovirus will not help them to resist risk behavior.

Through past experiences in teacher training, it has been determined that a one-time presentation for teachers is far from satisfactory. Training must be consistent and occur often with an initial "dose" and frequent follow-ups thereafter. It is essential to raise the comfort level of teachers who deal with delicate issues surrounding HIV education. Raising an instructor's comfort level will increase their intent to teach the curriculum.

Suggesting that a teacher present information about HIV prevention without appropriate training is dooming the curriculum to failure.

Inservice teacher training is costly because substitutes must be provided. Frequent absences of teachers from the classrooms interferes with the continuity of instruction for students. Funding is necessary for after school and week-end trainings.

Off-hour training opportunities lacking the enticement of stipends or inservice credits are often unsuccessful as they seldom motivate teachers to participate solely on the focus of professional enrichment. On the other hand, an extensive training program occuring during the school day can be equally unsuccessful. No matter how much funding is available, it will not supply additional teacher substitutes if they are not available, nor will it provide additonal weekdays when all disciplines are competing for comparable training time slots. In addition, the overuse of substitutes can hinder student achievement.

In a large system, there is often a lack of appropriate personnel to accomplish mammoth tasks involved in HIV education . There are also varying readiness levels of administrators and teachers in dealing with the HIV/AIDS information, and differences in perceived relative importance of the subject. Many believe it is not necessary to deal with HIV education in school and that the media should be allowed to do this task.

AIDS/HIV education involves more content to be added to an already filled curriculum.

In elementary schools, there is a general reluctance to deal with this subject. With such a large body of teachers, training everyone takes time and money.

HIV prevention education works best when integrated into a comprehensive health education curriculum. There needs to be continuity so that good health decisions become a part of life processes and behavior.

Federal, state and local governments can assist in the following ways:

a. Mandate comprehensive health as a graduation requirement for all high school seniors.
b. Mandate that health education be taught by well-trained health educators.
c. Provide inceased funding for teacher training.
d. Provide increased funding for instructional support materials due to rapidly changing information about HIV infection.
e. Assist with audio-visuals and additional materials directed to minority and special needs youth.
f. Provide financial support for activities targeted to reach out-of school youth.
g. Provide additional financial and technical support and opportunity for networking with national organizations to existing HIV prevention programs.

CDC-DASH provides technical assistance and guidance and is supportive to local control of HIV education programs. This has been essential in tailoring the activities to the specific population served. A framework is in place to which programs can be aligned. CDC-DASH, through a project officer, offers valuable suggestions and technical assistance concerning approaches to objectives and activities. Techniques and formats for evaluation design have been offered through a conference of LEA's and SEA's. CDC-DASH provides for and encourages networking and collaboration with national organizations.

In summary, CDC-DASH funding, technical assistance and networking support provides the impetus for school systems to produce viable HIV prevention programs for both in and out-of-school youth. Assistance in these areas from CDC-DASH has been instrumental in Baltimore City Public School's AIDS/HIV education effort for both in and out-of-school youth and the community at large.

TESTIMONY REGARDING AIDS EDUCATION FOR SCHOOL-AGED YOUTH

BY

KATHERINE FRASER
PROGRAM DIRECTOR
THE AIDS AND COMPREHENSIVE SCHOOL HEALTH PROGRAM
THE NATIONAL ASSOCIATION OF STATE BOARDS OF EDUCATION

BEFORE THE
SENATE COMMITTEE ON GOVERNMENTAL AFFAIRS

THURSDAY, MAY 3, 1990
9:30 A.M.

Mr. Chairman and members of the Committee: I am Katherine Fraser, Program Director of the AIDS Education Project at the National Association of State Boards of Education (NASBE). I am pleased to talk with you today about the efforts of our organization and the Centers for Disease Control to educate the nation's young people about AIDS and the virus, HIV, that causes it. State Boards of Education are interested in this issue because they are policymakers who are charged with outlining the response of state education systems to the AIDS epidemic.

NASBE is in its third year of a five-year project funded by the Centers for Disease Control. Our aim is to help states to dispel the myths about AIDS and give young people the information and skills to avoid HIV. We do this through giving on-site technical assistance to states, by producing publications to support policy development, and by providing national leadership about the broader health crisis underlying the AIDS epidemic that exists among our nation's young people.

Senator Glenn, our organization sees AIDS as a part of a bigger problem. State board members are very concerned about the health and well being of our nation's young people -- particularly on how this impacts their ability to learn, their motivation to graduate from high school, and their readiness to take their place in the world. Teenagers who are depressed, drinking too much, taking drugs, or who feel like they have no future -- are at risk of school failure.

For us, this means that schools need to be much more involved in supporting young people's physical and emotional health and well being than they have ever been in the past. This is not an idea that everyone agrees with -- others will insist that schools should limit themselves to promoting better academic achievement -- not health. But health and education are inextricably intertwined. Without better support for students' emotional, social, and physical problems, many of our young people will never graduate from high school or perform to their full potential. Schools can't solve these problems alone, but they must be partners with family and community efforts to do so.

Although our efforts span all age groups, we have taken a special focus on the health problems of adolescents for three reasons. First, too many of them suffer from avoidable problems such as drunk driving, drug abuse, and alienation. Second, adolescents are facing these problems at younger and younger ages -- when they are less able to cope and realize the consequences. And third, the results of these problems are more devastating than ever: unprotected sex results in not only unwanted babies -- but HIV infection and AIDS.

Out of this concern -- and with funding from the Centers for Disease Control -- NASBE has joined with the American Medical Association to form a prestigious commission -- the National Commission on the Role of the School and the Community in Improving Adolescent Health -- to draw national attention to our adolescent health crisis. The Commission, which is comprised of national opinionmakers in the fields of education, business, health, and the media will issue its report and concrete recommendations to the nation on June 8th.

With its CDC grant, NASBE also helps state leaders develop policies regarding AIDS education and people with AIDS. In the past years, we have visited one-third of all states, and because of our work, many states have adopted AIDS education requirements, as well as policies to help school communities make decisions regarding people with AIDS using methods that are medically sound and compassionate.

We have become a national and international center for information about AIDS and schools. Our latest publication, Someone at School has AIDS, has been requested by people from around the country and around the world to help them develop policies for people at school who are infected with HIV. We also conduct a yearly state-by-state survey of actions to promote AIDS education, and through this effort we have learned about the impact of our work: In the summer of 1987, 7 states required AIDS education. By 1990, this number has quadrupled: 30 states and the District of Columbia now require AIDS education.

Our obligations in regard to our grant include working cooperatively with CDC and other organizations, as well as having a project review panel review all of our materials. CDC also reviews our materials before they are published. We are also required to contribute to CDC's AIDS School Health Database. Next year, we will be required to participate in an electronic bulletin board that has been set up by the Council of Chief State School Officers.

I have also been asked to comment about how CDC can better coordinate federal, state, and local governments' programs with services provided by organizations such as ours. First of all, I want to tell you that I have worked closely with the Division of Adolescent and School Health for three years, and I think their program is first-rate. Like any ambitious and innovative new program, it has had its growing pains -- and this especially true since it had to respond to not only a public health emergency, but a highly charged political issue. I think that all of us have felt that we could hardly afford the time to pause over the past three years, because lives are literally at stake. At the same time, I think that this point -- 3 years into the process -- is an excellent time to think about how CDC and organizations such as NASBE can better work together to maximize our strengths.

CDC is a public health agency that is working with education -- and in doing so, is building bold new bridges between the fields of education and health -- and this is a great step forward in promoting the health and educational prospects of our young people. Two of the three top priorities of the CDC's new director, Dr. William L. Roper, are prevention of health problems and improving children's health. To prevent health problems of children, the public health system will be most effective if it works with schools -- because schools are where the children are.

Another strength of the CDC program is that through such activities as supporting our National Commission, CDC is raising awareness -- at many levels -- about the inadequacy of many health education programs to cope with serious problems such as AIDS. When health education is mentioned, many people remember their own experiences in which sometimes poorly trained and reluctant physical education teachers gave them lectures about sex or

the four food groups. If we hope to convince our teenagers to resist behaviors that could expose them to the AIDS virus, then we must think differently about health education. Students need relevant information from well-trained teachers, and they need to learn and practice the skills they need to live a healthy life. These skills include learning to make wise decisions, to work cooperatively with others, to resist pressure, and to take responsibility for themselves.

To strengthen their program over the coming years, I suggest that CDC continue to consolidate and use the results of one of its great successes: the capacity it has built in the diverse national organizations it has worked with over the past three years to improve AIDS and health education. With these organizations, they gain access to decisionmakers at all levels across the country -- people who have the energy, connections, and skills to make things happen -- at the local, state, and national level. As CDC works with individual states, it needs to build better and better ways to draw upon the information and experience of its funded organizations to plan strategies, build coalitions, and make real progress.

Second, as the CDC program continues, it should continue to work with state education agencies, and to help support their efforts, it should also forge stronger links with diverse groups at the state level -- including the nation's governors and legislators. This kind of leadership is crucial to CDC's long-term plan to effectively educate every young person about HIV and related health issues. Many states that have made a comprehensive, thorough statewide commitment to improving their AIDS and health programs have had the support of governors and legislators. It is often these leaders whose hearts and minds must be won to effect substantial, long-term change.

The AIDS epidemic remains a crisis, and it remains a highly emotionally and politically charged issue in many states and local communities. For this reason, we must continue to build coalitions at the state and local levels. It certainly will be easier to build state and local coalitions if we can make AIDS education a part of a bigger effort to improve the health and achievement of our young people.

I would like to express my sincere appreciation for having the opportunity to talk with you this morning. NASBE and its state board of education members stand ready to work with you in continuing to confront the national health crisis of the AIDS epidemic.

UNITED STATES SENATE

COMMITTEE ON GOVERNMENTAL AFFAIRS

HEARING ON AIDS EDUCATION FOR SCHOOL-AGED YOUTH

May 3, 1990

Testimony of Sandra McDonald, Founder/President

OUTREACH, INC. ATLANTA, GEORGIA

Good morning Chairman John Glenn, members of the Committee on Governmental Affairs and other observers and participants. My name is Sandra Singleton McDonald and I am Founder and President of OUTREACH, INC., a four year old minority non-profit grassroots community-based organization in Atlanta, Georgia.

OUTREACH, INC.'s overall mission and purpose is to provide culturally-sensitive AIDS and drug abuse education prevention programs to the minority communities in Metropolitan Atlanta's inner city neighborhoods and throughout the State of Georgia. To meet the challenge of our mission, we combine a two-prong educational approaches which utilizes both traditional and non-traditional methods. Our traditional approaches include training and informational workshops to groups including elementary, middle and high schools, colleges, churches, civic organizations, halfway house, drug treatment facilities and various others. Our non-traditional approaches include the formation of a "street

team" which consist of former intravenous drug users who are certified AIDS educators and provide one-on-one interventions to persons at elevated risk for HIV disease.

During 1989, our street team made 95,000 personal contacts with current substance users, their partners and other family members, out-of-school youth, and others in the minority community where distribution of 200,000 condoms, 2,000 of individual bleach bottles and 150,000 instructional brochures were handled. Other approaches have included sponsoring a female impersonation contest where AIDS education was provided prior to announcing the winner to black gay males; placing Peer Counselors (recovering intravenous drug users who are AIDS educators promoted form our street team) in our largest charity hospital, Grady Memorial to intervene with addicted patients with HIV disease to encourage drug treatment, 12 step-help programs and general emotional support; and, adopting an inner city high school and an alternative school for out-of-school youth to begin a Teen Peer Program.

My testimony this morning will center around out HIV awareness programs targeted at school-aged youth.

IN SCHOOL YOUTH PROGRAM

Outreach, Inc. was contracted by the Center for Population Options, a national organization funded by the Centers for Disease Control's Adolescent and School Health HIV Education Program, in August, 1989 to begin a Teen AIDS Prevention Program at a local middle or high school. The contract was for $2,500 and covered a one year period. Since the Atlanta Public School System did not have a formal program for AIDS education in place for students, we were fortunate to be given permission to operate in an inner city high school where two (2) students under sixteen years old were recently killed in drug related fights in the last twelve (12) months. Students were chosen by the school's officials for participate and parental approval was obtained.

A course outline and general program operations were provided by the Center for Population Options and have been followed by the fifteen (15) students participating in the program. The students meet for two (2) hours each week and in addition to the course requirements a variety of guest speakers provide training on pertinent diseases, teenage pregnancy, suicide, homicide, peer pressure, stress, etc.

The students chose as their project to develop a Teen's AIDS Awareness Workshop targeted at their peers and to conduct

a minimum of one (1) workshop for 10th, 11th and 12th graders at (10) major Atlanta high schools. A peer level brochure, poster and referral card developed by the students will be provided. During the summer months, the students will begin a "Teen Crisis and Self-Help Line" where calls from teens seeking information about AIDS and/or drug abuse will be received. This telephone line will be located in our administrative offices and one of our Outreach Specialist will assist the students. The availability of this service and the appropriate telephone number will be advertised at establishments frequented by teens including record stores, pizza parlors, skating rinks, etc. Public service announcements written by the students will also be placed on local radio stations.

OUT-OF-SCHOOL YOUTH PROGRAM

Our first encounters with school-aged youth who were not in school began in 1988 when our initial "street" outreach work started. Our Outreach Specialists (who are trained AIDS educators and recovering Intravenous/substance users) began to observe several young minority males who were regulars at local recreation centers where basketball in played most of the day. After developing a level of trust and creditability, the youth were receptive to information on the transmission of HIV and

prevention techniques. While acceptance of condoms was slow as first, it rapidly became our hottest item.

In inner city Atlanta, it is difficult to identify any one section of town where out-of-school youth congregate, however, we continued to discover these youth in areas where drugs dominate and where sex, money, stoles items and others are exchanged for crack cocaine, powdered cocaine and heroin. We recruited two (2) youth who were seasoned "street wise" veterans to distribute informational brochures, condoms and bleach to other kids on the street. These youth also became our entrance into other areas where out-of-school youth including runaway gathered. Jo Bergman, Vice President of Warner Bros Records has been a supporter of our Teen Program and has provided cassette tape, albums and compact discs which are used as an incentive for kids to talk to us on the streets.

Currently, we have recruited five (5) students at the Exodus, Inc. Academy (an alternate school for out-of-school youth, runaways, troubled students, etc.) to become Teen Peer Counselors for youth on the street sand will begin their training program when funds can be obtained for stipends. These students will work in concert with our in-school youth on various projects including the Crisis Line and the peer level workshops.

RECOMMENDATIONS

We strongly recommend and encourage the consideration of the following:

* Funding be continued for the Centers for Disease Control's Center for Chronic Disease Prevention and Health Promotion's Division of Adolescent and School Health HIV Education Program for both in-school and out-of-school youth.

* Out-of-school youth programs include:

  - the flexibility of designing written materials which reflect the language of "street wise" kids and is culturally suited for different audiences i.e. rappers, punk rockers, heavy metal followers, etc.

  - the participation of community based organizations who offer substance abuse information and treatment programs targeted towards teens; and

- an Advisory Panel of former runaways, out-of-school youth, etc. to provide guidance on appropriate intervention methods and techniques.

* CDC's CCDPHP develop partnerships with corporations whose products are marketed to teens to solicit participation is providing AIDS awareness information with purchases. Examples include fast food restaurants, record stores, tennis shoe companies and other.

* Efforts to provide education to youth on all health issues by the Center for Chronic Disease Prevention and Health Promotion's and other agencies, be incorporated with AIDS awareness information for a comprehensive method of communication. Examples include drug abuse education, other sexually transmitted disease, teenage pregnancy, etc.

* Removal of several restrictions on HIV education and prevention activities. **Thank you!**

The National Network

of Runaway and Youth Services, Inc.
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TESTIMONY
OF THE
NATIONAL NETWORK OF
RUNAWAY AND YOUTH SERVICES

BEFORE THE

COMMITTEE ON GOVERNMENTAL AFFAIRS
U.S. SENATE

HEARING
ON
AIDS EDUCATION FOR SCHOOL-AGED YOUTH
MAY 3, 1990

PRESENTED BY

JAY M.S. COBURN
DIRECTOR, SAFE CHOICES PROJECT
THE NATIONAL NETWORK OF RUNAWAY AND YOUTH SERVICES

Chairman Glenn and members of the Committee on Governmental Affairs, my name is Jay Coburn. I am Director of the Safe Choices Project at the National Network of Runaway and Youth Services. I am here today representing the National Network, our members, and the thousands of young people who are living without the support of our schools and other institutions as they struggle toward adulthood. I am also here to share the experiences of other national organizations which receive funding from the Division of Adolescent and School Health (DASH) to provide education services to out-of-school youth.

Thank you for the opportunity to speak before this esteemed panel on matters that could save the lives of so many disenfranchised young people. I would like to tell you about the work of my organization and project, briefly profile those youth who are at highest risk for HIV infection, outline our current efforts to prevent HIV infection within this group, and discuss the prevention initiatives overseen by the Division of Adolescent School Health (DASH) at the Centers for Disease Control (CDC).

The National Network

The National Network of Runaway and Youth Services represents over 900 community-based organizations throughout the country as it educates and assists the nation in providing support and services for high-risk youth and their families, so they may lead safe, healthy, and productive lives. To that end, Safe Choices is a national initiative to provide materials, training, and technical assistance in HIV and AIDS prevention to those who serve runaway, homeless, and other high-risk youth. In addition, the project provides information on high-risk adolescents and HIV and AIDS to national organizations and policy makers.

Youth and HIV

Adolescence is a time of experimentation for most young people, as they assert their independence from parental figures and begin to explore new ideas and behaviors in preparation for adulthood. Unfortunately, this experimentation increasingly includes early sexual activity and alcohol or drug use, placing youth at risk for a variety of health problems -- including HIV and ultimately, AIDS.

Sexual Activity

- On average, young women first have sexual intercourse when they are 16.2 years old; for young men, the average age is 15.7 (Zelnick & Shah, 1983). For most, the decision to have sexual intercourse is spontaneous (Zelnick & Shah), decreasing the likelihood that condoms will be used to prevent the transmission of disease or unwanted pregnancy.

- The average age for first sexual intercourse reported among young women in an inner city detention population was 12 years old (Hein & Hurst, 1988).

- One in six high school girls who is sexually active has had at least four different partners (Madaras, 1988).

- In a study that focused on health services to homeless people in 19 cities, homeless girls aged 16-19 had the highest pregnancy rate of any other age group. Thirty-one percent of the 16-19 year olds receiving health services were pregnant, as compared to 9% of the control group used (Wright, 1989).

STDs

- 2.5 million teenagers, or about 1 in 6 teenagers, contract an STD every year (Madaras, 1988).

- People with a history of sexually transmitted diseases (STDs) appear to have a higher incidence of HIV infection than people with no such history (Cates, 1988).

- For sexually active teens, latex condoms are the best way to avoid HIV infection. However, only about 25% of teens (aged 15-24) use contraception consistently; only 21% of these use condoms (Bachrach, Horn, Mosher, & Pratt, 1984).

Alcohol and other drug use

- Among adolescents surveyed in 1987, about 1/4 of 8th graders and more than one-third of 10th grade students reported having had five or more alcoholic drinks on one occasion during the previous two weeks (American School Health Association, 1987).

- Reported rates of substance abuse among runaway and homeless adolescents range between 70-85% (Shaffer & Caton, 1984; Yates, MacKenzie, Pennbridge, & Cohen, 1988; Rotheram-Borus, Koopman, & Bradley, 1989).

- Use of drugs and alcohol by teens impairs judgement, leading to poor decisions about engaging in sex in the first place. Drugs and alcohol also impair a person's willingness and ability to use condoms or other precautions.

At this time, several hundred young people aged 13-21 have been diagnosed with AIDS. AIDS is the 7th leading cause of death among 15-24 year olds in the U.S.; it moves to 4th place when looking at health-related deaths (National Center for Health Statistics, 1990). Health care experts assert that these numbers mask the true

incidence of HIV infection in adolescents, since those infected with the HIV-virus as teens are usually asymptomatic until sometime in their twenties. (The latency period for the HIV-virus may be as long as 10 years. Currently, 20% of those individuals diagnosed with AIDS are aged 20-29; many of these were probably infected as teenagers.)

Cases of AIDS among older adolescents differ from younger children in that the virus is: a) most often transmitted through unprotected sexual activity or sharing needles and b) can be prevented when young people are given the information and gain the skills necessary for behavior change. Adolescent infection also differs from adults in several ways: a higher percentage of females are HIV-infected; the rate of heterosexual transmission is double that of adults; and there is a higher prevalence in young people of color.

High-Risk Youth

Youth at highest risk for HIV infection face the same developmental challenges as other youth: they experiment, test limits, and believe they are invulnerable. As far as HIV, they are often isolated from the institutions that are typically expected to carry prevention messages -- schools, families, health services. Unfortunately, they lack the adult support and resources which help to ensure healthy transitions into adulthood. They miss school or drop out, engage in sexual activities at earlier ages, and are more apt to become chemically dependent on alcohol and other drugs.

Runaway and homeless youth are particularly vulnerable. Life on the streets appears to be the most viable option for many of the estimated 1.3 million youth who have fallen through the cracks of an overburdened child welfare system or who have fled or been ejected from chaotic and often abusive homes.

Although these young people come from diverse backgrounds (i.e., they represent every socioeconomic class, ethnicity, and community), living without adult support and guidance is a great equalizer. Runaway and homeless youth often lack access to things many adults take for granted: bathrooms, places to bathe, warm and safe places to sleep, regular meals, transportation, and people in their lives whom they can trust.

Because of their age and lack of education or job training, these young people have few skills or life experiences with which to earn a living. They are easily exploited. Drugs and alcohol (which impair judgement) are often used as means to fit into the street scene, escape from the pain of the past, or ease a sense of hopelessness in the present. In addition, youth are forced to engage in survival sex to meet their basic needs of food and shelter.

Runaway and homeless youth often lack HIV prevention information, the negotiation skills necessary to practice safer behavior, and access to condoms (or bleach to disinfect needles). Also, the adults who sexually assault or exploit these teenagers are rarely interested in risk reduction; they pay and/or coerce youth to forego condom use. Too often, because of their profound isolation, these youth lack the will to save their lives through less risk behavior.

Currently, programs that counsel runaway and homeless youth in New York City report that 7-15% of their clients who have been tested for the virus are infected (Kennedy, 1988). Prevention and intervention is very difficult given the complete lack of stability in these young people's lives. Just securing shelter on a day-to-day basis and remaining relatively safe from assault is consuming.

Getting these young people off the street, away from the pressures and exploitation that makes them more susceptible to risky practices, is bottom-line HIV prevention. At the same time, street outreach and youth emergency shelter programs act as the point of access for many high-risk youth into the service delivery system; they are strategically poised to provide HIV prevention education to young people who are, for the most part, disconnected from their communities and responsible adults.

Characteristically, the focus of these programs is crisis intervention, stabilization, reuniting families, and brokering additional services for young people (e.g., getting the child welfare agency to take custody when an under-age youth has been abused or neglected.) With training and assistance, community-based agencies can also help young people change their behavior to make them safe from HIV.

Safe Choices Project

The Safe Choices Project has received funding from the Division of Adolescent School Health (DASH) of the Centers for Disease Control (CDC) for the last three years. The purpose of the cooperative agreement is to expand HIV prevention activities benefitting out-of-school youth -- specifically, runaway, homeless, and other troubled youth. Working with community-based organizations that reach out to high-risk youth, the project has four parts: educational materials, training, technical assistance, and public information and networking.

The Safe Choices Guide. The Guide, a central component of the project, is designed to help youth-serving organizations develop policies and programs to help stop the spread of HIV -- including runaway and homeless youth centers, detention facilities, and group homes.

The Guide consists of the following modules:

- organizational policies about AIDS and HIV infection (e.g., safety procedures, anti-discrimination policies)
- staff training for all employees who come in contact with youth (i.e., line staff, counselors, cooks, drivers)
- youth training, including basic information and skills-building exercises
- individual and family counseling
- outreach to street youth
- telephone hotline information, counseling, and referral
- HIV prevention in foster care settings

CDC has funded development and printing of the Guide along with additional financial support from the Metropolitan Life Foundation. The Guide will be disseminated to the 343 federally-funded runaway and homeless youth centers, and additional copies will be made available to youth-serving agencies nationwide. Final approval on the text of the Guide was received from the CDC on April 27, 1990. Now in production, the Guide is scheduled for distribution at the end of May.

Workshops and Training. Sessions are held throughout the country to alert youth workers to the impact of the epidemic on young people and to train program staff so they can provide effective HIV prevention education. The one-to-three hour workshops are typically convened at national and regional conferences. They are designed to introduce participants to the issues affecting high-risk youth and HIV.

Intensive training conferences, based on the Safe Choices Guide, increase participants' knowledge and competencies in the following areas: organizational policies, training for staff, HIV prevention for youth, and integrating HIV prevention messages into existing counseling, street outreach, hotline, and foster care programs. In addition, participants become familiar with local resources and learn about networking and organizing community responses to fight HIV.

In the first half of this fiscal year, Safe Choices has reached 387 youth workers, teachers, and other professionals through 11 presentations held throughout the country -- e.g., Angel Fire, N.M.; Stevens Point, Wisc.; Richmond, Va. Intensive, one- to two-and-one-half day trainings have been held in five cities during the same period, including: Washington, D.C.; Houston, Tex.; Pittsburgh, Penn.; Springfield, Mass.; and Ashland, Ore. By

October 1, 1990, community-based organizations serving high-risk youth in each of the ten federal regions will have had the opportunity to participate in these sessions.

Technical Assistance. The project provides technical assistance, namely, support and information on model programs, policy development, private funding sources, and new materials (e.g., posters, brochures, videos) through a variety of channels:

- The AIDS Technical Assistance Hotline (1-800-878-AIDS) provides personal assistance in developing programs and finding new materials for those serving at-risk youth.

- The YOUTHNET AIDS Bulletin provides weekly updates on HIV prevention and other activities through the National Network's telecommunications system, YOUTHNET.

- The "Network News" and "Policy Reporter" are National Network publications that carry HIV/AIDS related articles to inform and educate youth providers.

Safe Choices is also providing intensive and ongoing technical assistance to seven youth shelters in the Washington, D.C., metropolitan area. In recognition that agencies working with high-risk youth are often constrained by limited staff and other resources, Safe Choices provides a half-time trainer shared by the shelters. Funded through a grant from the Aetna Foundation, the trainer is able to provide assistance to agency staff and training to clients every two weeks at each shelter. Depending on evaluation outcomes, this model may be replicated in other communities in the future.

Public Information and Networking. These activities are critical to developing greater public understanding and support for additional HIV/AIDS services for high-risk youth. Project staff work with other national organizations and decision makers to increase awareness and to facilitate cooperation at all levels of community that cuts across public/private, professional, and ethnic/cultural lines. DASH's cooperative agreements with 20 national organizations emphasize collaborative efforts; to that end, several national organizations hope to hold joint training next year for their respective constituents in select cities across the nation.

DASH and Prevention Initiatives

Effective HIV prevention for all youth, particularly youth at risk, must provide information and skills. Teaching young people about how HIV impairs the immune system will not help them if their sexual partners refuse to use a condom. Young people need refusal and negotiation skills and explicit information if they are to abstain from risky behaviors or reduce their risk by using condoms.

A recent study on HIV prevention for high-risk youth conducted at Columbia University found that young people had a high level of knowledge about HIV transmission (Rotheram-Borus, Koopman, & Bradley, 1989). However, they lacked negotiation skills and despite their high level of knowledge, they continued to engage in high-risk behaviors with multiple partners. An effective behavioral change intervention required ten, one-hour sessions providing explicit information and skills in order to initiate a positive change in risky behavior. Sustaining that change demanded additional support. These results underscore the importance of addressing age-related challenges and stabilization issues when designing prevention education programs for out-of-school youth.

Obviously, communities need highly skilled trainers to work with these young people. Funding community projects that hire a trainer(s) who is shared among community-based organizations is a cost effective model for providing prevention education. In addition, it has the added benefit of encouraging cooperative efforts at the local level.

Numerous federal agencies within the Public Health Service (e.g., CDC Center for Prevention Services, National Institute of Mental Health, National Institute of Drug Abuse) are beginning to provide resources to community-based agencies serving out-of-school youth. However, there is little coordination between agencies and no sharing of resources and model programs.

Recommendations

- **The Public Health Service (PHS) should increase coordination among federal agencies making HIV prevention grants to community-based organizations targeting out-of-school youth.**

- **More funds must be made available directly to community-based organizations to provide the intensive training to out-of-school youth necessary to initiate and sustain behavior change.**

- **The Centers for Disease Control (CDC) should modify current restrictions on the content of HIV prevention messages to allow the use of targeted materials proven to be effective by public health experts, even though they may offend some audiences.**

The Centers for Disease Control's HIV prevention initiative for out-of-school youth is currently based within DASH. At first glance, the wisdom of making departments of education responsible for students who appear to have left their system may seem questionable. However, practice yields other conclusions.

First of all, the boundaries separating in-school and out-of-school youth are permeable. Youth may be in and out of school over

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periods of time due to a variety of circumstances: runaway episodes, a family crisis such as loss of the family home, needing to work during school hours or take care of younger siblings, changing foster care placements, and simple truancy are among the reasons school-aged youth may not be in school. In addition, some youth who may ultimately drop out often vacillate over time between quitting school and resuming attendance.

Secondly, schools know young people and the technologies that enhance their learning better than any other system. They have experience, and there is precedent for them to educate youth who are out-of-school (e.g, in a majority of states, schools must already provide education to incarcerated, out-of-school youth).

Often when young people are troubled or become disconnected from society, there is a tendency to forget their age and serve them solely on the basis of their problems. It is assumed, for example, that adult or family homeless shelters serve youth or that a teenager with drug problems can be served by any rehabilitation program. In reality, minors are often denied service at these adult-oriented programs and if they are served, youth are exposed to the influence of very troubled adults in programs that are not tailored to meet their developmental needs.

Out-of-school youth need help in preparing for adulthood. If schools are going to respond to the much discussed crisis in education and prepare the work force of the future, they need to reach out to those young people who struggle within and without the educational system. It is not enough to find ways to keep young people invested in the educational process during and after junior high school, adolescents who have left school need encouragement and help in reconnecting with school. The DASH program reinforces this involvement.

Finally, DASH's initiative requiring the educational system to respond to the needs of out-of-school youth is resulting in unique and effective partnerships between public agencies and community-based organization's that serve these youth. Examples of collaborations which have included the Safe Choices Project follow:

- The Wisconsin Department of Public Instruction, the state educational agency (SEA), provided funding to bring together all the runaway and homeless youth programs in that state for a day-long training in cooperation with the Wisconsin Association of Runaway Services.

- Safe Choices staff have provided technical assistance to 24 state teams of public and private agencies at three, DASH-sponsored conferences.

- In Arizona recently, 150 professionals from public agencies (e.g., schools, health departments) and private community-

based organizations who work with high-risk youth attended a two-day training convened by the SEA. The SEA worked with the National Network to identify runaway programs in the state and invited Safe Choices Project staff to present at the conference.

- Next week in Columbus, Ohio, youth workers from throughout the state will attend a two-and-a-half day training provided by Safe Choices. They will be joined by representatives of the Ohio SEA, the American Medical Association's DASH-funded Youth HIV Education Project, and private industry, which is interested in providing private sector funding to community-based organizations.

- Safe Choices will provide three intensive training conferences in Virginia this fall to groups convened through the Virginia Department of Education for public and private agencies.

However, these collaborative relationships need to be expanded and DASH should continue to require SEAs and local educational agencies (LEAs) to work more closely with community-based youth-serving agencies. Some SEAs and LEAs still lack expertise in reaching out-of-school youth. DASH should use its six national organizations serving these youth to provide technical assistance to SEAs and LEAs.

Recommendations

- **The Centers for Disease Control's HIV prevention efforts targeted at out-of-school youth should continue to be coordinated by the Division of Adolescent and School Health.**

- **DASH should continue to require SEAs and LEAs to work with community-based agencies in reaching out-of-school youth.**

- **DASH should increase funding to national organizations (that work with constituencies serving out-of-school youth) to enable them to provide more comprehensive technical assistance to SEAs and LEAs.**

These historic partnerships will ultimately benefit out-of-school youth through teaching those who are already working with them how to become HIV prevention educators and by teaching educators the needs of these youth and how to best reach them. Under the Federal Government's leadership through the programs of the Division of Adolescent and School Health, communities are finally banding together to address the myriad problems facing high-risk youth and their families. DASH's efforts should be continued and strengthened.

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DIVISION OF HEALTH SCIENCE

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April 9, 1990

Judith Senderowitz
Teens for AIDS Prevention (TAP)
Center for Population Options(CPO)
1012 14th Street, NW - Suite 1200
Washington, DC 20005

Dear Judith:

Congratulations on being selected to receive an award in the AMA National Congress on Adolescent Health Awards Program! We had nominations from many excellent programs and outstanding individuals this year, and you are certainly among a select group of those our reviewers chose for us to recognize. I would like to first clarify what our recognized programs and individuals can expect and begin to make arrangements for you to receive your recognition.

The award plaques and certificates of merit for honorable mentions will be given out at a special reception at the AMA National Congress on Adolescent Health in Washington, DC on Friday, May 11, 1990. The reception will be from 5:00 - 7:30PM. We hope that a representative of your program can be present to receive the award and share your work through a poster display. Conference registration fees have been waived for one person from each program receiving an award or honorable mention. Registration materials for both the conference and the hotel are enclosed. Please send these in as soon as possible. Award winners will receive a check for $600 at the reception to defray costs of attending the conference.

The enclosed 1990 AMA Poster Session/Awards Presentation Planning Form lists the title of your program as it will appear on your plaque/certificate. Please read this over and make any corrections needed. Since plaques and certificates must be ordered soon, Kelly Koski, our Administrative Assistant, will call to check on needed corrections.

All award winners and persons receiving honorable mentions are invited to create a poster display describing their work. The poster displays will be presented during the reception and will be available for conference participants to review the following morning as well. You will have a six foot table and a four foot by eight foot corkboard to display materials describing your work. The Planning Form also asks about your electrical needs for your display. Please let Kelly know any electrical outlets or equipment needed for the display when she calls. Please note: there is a charge for videorecorders and slide projectors.

Materials for the poster displays should be shipped to the hotel ahead of time. A shipping label for the hotel which lists your table number is enclosed. The poster display materials must be shipped to the hotel via 2-day UPS by May 3. If a representative from your program cannot attend the Congress, you may ship materials to be displayed at the Congress. Our staff will ensure that these are displayed and returned to you.

In addition to these arrangements, we will be sending you a sample press release to use in informing the media about your recognition. The press release will have spaces for you to insert your own individual information. In previous years, many local and regional state media featured stories on recognized programs. A photographer at the reception will take a picture of each person receiving a recognition. These pictures will be sent to you to use in later publicity releases. We are also planning to distribute information on our honored programs and individuals through various AMA media. Portions of the awards presentation will be featured on AM Television which airs on the Discovery channel. Several programs and individuals will be featured in *Target 2000* a newsletter sent to 4,000 health professionals across the U.S. Abstracts of the recognized programs and individuals will also be published as a booklet to be distributed to persons requesting information on adolescent health programs from the AMA.

If you have any questions about these arrangements, please call me or Kelly Koski at (312) 645-5575. I look forward to talking with you and hope to meet you at the Congress.

With Warm Regards,

Kathy Voegtle

Kathy Voegtle, Ph.D.
Awards Program Director

CORPORATION FOR PUBLIC BROADCASTING

Donald E. Ledwig
President and
Chief Executive Officer

May 18, 1990

The Honorable John Glenn
Chairman
Committee on Governmental Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

It has come to my attention that the Committee on Governmental Affairs held a hearing on May 3, 1990, on the topic of AIDS education of school-aged youth. I would like to offer for inclusion in the hearing record a brief description of one effort by the Corporation for Public Broadcasting (CPB) to apply its own experiences and resources to this particular issue.

CPB is a nonprofit, nongovernmental corporation authorized by the Public Broadcasting Act of 1967 to facilitate the development and distribution of high-quality public service programming to all Americans. Since its inception, it has been a priority of CPB's to make public broadcasting programming available to those unserved and underserved by other broadcast services. As one example, CPB is well known for its leadership in identifying and supporting educational programs and materials.

Last year, the Corporation and the Public Television Outreach Alliance, which works with communities on major social issues such as AIDS, literacy, and child care, sponsored a nationwide High School AIDS Education Video Contest. Students were asked to produce videos that would provide the facts about AIDS to their fellow teens. Clips from the winning videos and other entries were incorporated into a longer AIDS education video which is now being used in the schools as part of a comprehensive AIDS education effort.

The final product is a 25-minute video entitled Stop AIDS!, consisting of nine student videos of varying lengths and styles, ranging from lighthearted skits and dramatizations to an emotional look at the impact of AIDS on a teenager who has lost a friend to the disease. Students use contemporary themes to creatively broach a difficult

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subject and to communicate, in familiar language, vital facts about AIDS to fellow students. The video is accompanied by a teacher's guide and can act as a catalyst for classroom discussion of the subject.

Thus far, 3,500 copies of the video have been distributed to public television and radio stations, schools, community organizations, hospitals and clinics, nationwide. Segments of the video have been aired by commercial news programs as an example of AIDS education tactics in the teenage community.

Public broadcasting has played, and can continue to play an important role in educating our youth about many of the major social problems facing the Nation today. As you continue to take a leadership role in this critical issue, I urge you to consider CPB and public broadcasting as a foundation that this committee can build upon for a better informed America.

Sincerely,

Donald E. Ledwig
President and
Chief Executive Officer

YouthCare
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Gang Prevention Services

Formerly Seattle Youth and Community Services
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Telephone 206/622-3187

May 1, 1990

Deborah Cohen
Staff to United States Senate
Committee on Governmental Affairs
340 Dirksen
Washington, D.C. 20510-6250

Dear Ms. Cohen:

Thank you for the opportunity to provide written testimony to the Senate Committee on Governmental Affairs. I am happy to provide information regarding YouthCare's work with HIV/AIDS education efforts, particularly the work we do in partnership with CDC.

CDC's work, in conjunction with youth service agencies throughout the nation, has been very positive and much needed, however, we have only begun the huge task of educating youth at risk of HIV infection.

I cannot urge the committee strongly enough to expand its efforts on behalf of youth in crisis throughout our country.

Please do not hesitate to contact me if I can provide anything further to the committee.

Sincerely,

Victoria A. Wagner
Executive Director

enclosures

VW/KAN/testaida/501

Thank you for inviting my testimony regarding HIV and adolescents. Of all the issues facing runaway, homeless and high risk adolescents, AIDS is among the most critical. Due to the deadly nature of this virus and the risk it presents to young people, YouthCare has made AIDS Prevention programming a top priority in our service delivery system.

YouthCare has worked with runaway, homeless and abandoned youth since 1974. Through a collaborative HRSA Pediatric AIDS grant with Seattle-King County Public Health in 1988, the agency received funding to provide HIV/AIDS prevention education to high risk youth and develop an Adolescent Health Promotion Program. This program serves incarcerated youth, youth in drug/alcohol treatment programs, youth in runaway shelters and those youth living on the street. The program staff reach between two and three hundred youth per month. The youth range in age from 10 to 19 (median 16.2); 44% are youth of color; 50% are white (6% unknown). A 1987 survey of 250 of these youth indicated that 91% were sexually active and 83% had used drugs and/or alcohol in the past 6 months. Twenty one percent had used IV drugs and 65% of these reported sharing needles. Of the youth who shared needles, 2/3 reported "usually or always" cleaning their needles, but only 1/3 cleaned with bleach. These statistics clearly indicate that these youth are at high risk of HIV infection and require effective HIV/AIDS prevention messages.

In 1989 YouthCare, again through collaborative efforts with Seattle-King County Health Department, was awarded funds through the Robert Wood Johnson Foundation to further expand AIDS prevention programming. A major component of this program is a three part HIV/AIDS curriculum for youth. The curriculum's first segment includes a basic discussion of HIV/AIDS, an audience appropriate video presentation, condom demonstration, needle cleaning demonstration and description of risky behaviors and how to modify them. The second segment is a meeting with a person living with AIDS or ARC. The third segment is an activities group with poster making, writing a letter to the PWA and responding to any issues the youth may have.

The current evaluation method for this program is a pre and post session test administered to the youth. The evaluation has shown a marked improvement in HIV/AIDS knowledge after program completion and youth indicate that they intend to engage in safer behaviors.

Other services through this funding include a peer theater project and the production of youth targeted materials (posters, brochures). In addition we have developed a Teen AIDS Prevention Education (T.A.P.E.) training for youth service providers which offers a practical, skills-building course to address risk reduction activities for adolescents.

This course is currently being evaluated by the University of Washington School of Social Work. Among other findings, initial evaluation results have shown that those who received the training have provided HIV/AIDS education to over 1,500 youth in the first year.

The final portion of Youthcare's Adolescent Health Promotion Program comes through a CDC funded project. This is part of a larger CDC demonstration project to the Seattle-King County Health Department that has been in operation since 1985. This program continues the community based demonstration project focusing on three hard-to-reach risk groups in need of HIV/AIDS information. YouthCare's participation in the demonstration focuses on street youth at high risk for HIV infection.

YouthCare, under this CDC contract, is conducting an ethnographic survey of street youth to develop a specific HIV/AIDS intervention for that population. YouthCare is conducting a series of interviews with those agencies and individuals that interact with street youth. Interviews range from executive directors of youth shelters to youthworkers to video arcade owners to those who pimp or otherwise exploit at risk youth. Once we know more about where these youth are, they are interviewed about how they and their peers get information about AIDS and what methods would more effective. Focus groups will also be conducted

to get comments regarding the specific kinds of AIDS/HIV information this population needs and wants.

An intervention plan will be developed from these interviews in conjunction with the staff from CDC and used at several sites. Finally cross sectional surveys of street youth will be done to see if youth have been impacted by this process. Over 100 youth will be involved in the research and another 2,500 will receive the intervention over the course of the contract.

At the end of each series of interviews a report is compiled and reviewed by CDC staff. Additionally we have had several meetings, conference calls and consultations with CDC and their contractors.

Although only in the beginning stages the project has so far identified ten different subsets within the street youth population. Due to past educational efforts these youth have been found to have a high degree of knowledge regarding HIV/AIDS, however numerous reasons have also been identified by those interviewed as to why youth fail to use safer practices. An abbreviated list includes: adolescent invincibility; youth think condoms don't work or are unnatural; because they are in a relationship they can't get AIDS; self esteem issues inhibit them from being assertive; lack of skill regarding condom usage; peer pressure

regarding drug use; the use of sex for survival; getting more money to have sex without a condom; lack of discipline/responsibility; a fear of discussing sexuality; tendencies toward rebellion/self destruction; condoms are perceived as a threat to masculinity; young women want to be pregnant; youth are unable to access condoms; and the list goes on.

It is clear that we need to find and explore new and innovative ways to promote safer practices with the adolescent population. It is only through federal resources that we will be able to find and disseminate these methods nationwide. Although the statistical incidence of HIV is low in adolescents we are all aware of the dramatic increase in a diagnosis of HIV infection in the 20 to 29 age bracket. Given the incubation period for the HIV virus, many are contracting the disease in their adolescence.

The information and education CDC, through it's contracting agencies, provides today, is critical to ensure and safeguard the health and well being of these young people as they move into adulthood. I urge members of this committee to make funding and programming for HIV risk reduction a CDC priority for the adolescent population. Without additional resources, existing programming is a singular and temporary splint holding together a fractured health care system.

Submitted April 30, 1990 by:

Victoria A. Wagner
Executive Director
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Seattle, Washington 98101
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ADOLESCENTS AIDS AWARENESS

Evaluation of an AIDS Prevention Program for Runaway and Gay Youth in NYC

Principal Investigator: Mary Jane Rotheram-Borus, Ph.D.

Researchers: Cheryl Koopman, Ph.D.
Clara Haignere, Ph.D.
Hector Bird, M.D.

Presented at the American Academy of Child and Adolescent Psychiatry Annual Meeting - October, 1989 - New York

ABSTRACT

This study evaluated the effects of an AIDS prevention intervention targeting runaways and gay adolescents. Thirty-nine intervention group runaways, 33 intervention group gay males, and 62 control group runaways and gay males participated in this study. General knowledge about AIDS, attitudes towards preventing AIDS, and safer sex practice (abstinence, number of sexual partners, number of sexual encounters, condom use) were assessed in an individually-administered clinical interview using a structured protocal. The intervention was provided at one of the runaway shelters and at the community program for gay and lesbian youth. The ten session intervention included four components: General knowledge about AIDS, attitudes toward preventing AIDS, coping skills and developing access to comprehensive health services. Control group subjects received only a 2-3 session "state of the art" AIDS prevention program. Adolescents were tracked with followup interviews administered at three and six months after baseline interviews. Preliminary analysis of the results suggests that there are significant differences between the intervention and control groups at 3-months and 6-months on several sex risk behavior variables. The most important effect of the intervention may be to reduce the number of youths engaging in a high risk pattern of infrequent condom use in conjunction with many sexual occasions or multiple partners.

METHODS

We have been evaluating a control group and a group of runaway and gay youths at three community- based service agencies in New York City over the last year. Each of the youths receiving the intervention have received at least ten sessions of 1 1/2 to 2 hours each. The sexual behavior patterns of these youths are assessed prior to the intervention and at three month intervals. To date we have analysed the data for 6[illegible] youths in the control group for three and six months. There are 37 youths who have completed the intervention whom we have followed for six months.

Safer sex practices (abstinence, number of sexual partners and encounters, condom use) were assessed with the Sexual Risk Behavior Assessment Schedule- Youth Baseline Interview (Meyer-Bahlburg, Ehrhardt, Exner,& Gruen,1988).

Adolescents were consecutively recruited into the study from two runaway shelters and a community program for gay and lesbian youth. Runaways were recruited if they remained in the shelter for a minimum of 48 hours. Informed consent was obtained from each youth before beginning data collection. Data were collected by trained interviewers in an individually-administered, clinical interview using a structured protocol. The intervention was provided at one of the runaway shelters and at the community program for gay and lesbian youth. The ten session intervention includedfour components: general knowledge about AIDS, attitudes toward preventing AIDS, coping skills, and developing access to comprehensive health care services. Control group subjects received only a 2-3 session "state of the art" AIDS prevention program. Adolescents are being tracked with followup interviews administered at three months after baseline interviews.

RESULTS

1) Sexual abstinence is higher after the first three months in the intervention group (19% of controls versus 54% of the intervention group). This impact is gone at six months (36% of controls and 38% of the intervention).

2) The number of youths engaging in a "high risk pattern" (i.e. infrequent condom use, multiple sexual partners and frequent occasions of sexual intercourse) is lower in the intervention group than in the control group. There were eight youths in the control group with such a pattern and one in the intervention group after six months.

3) The number of youths reporting consistent condom use among the intervention group (7 of 18 sexually active youths at three months; 8 of16 at six months) appears higher than the number in the control group (8 of 41 sexually active youths at three months; 6 of 40 sexually active youths at six months).

4) Males, both runaway and gay, appear to be engaging in the "high risk pattern" more than females. Eight of the 9 exhibiting the "high risk pattern" were males, 4 of whom self-identified as gay. In the control group, there were no male runaways reporting consistent condom use at three and six months, even though there were 14% at the baseline.

We emphasize that these results are preliminary and more youths will soon be reaching the follow-up points. We do feel encouraged when examining these findings that the intervention may ove. time demonstrate a positive impact.

FOUR COMPONENTS OF THE PREVENTION PROGRAM

I. General Knowledge of AIDS

II. Personalized Knowledge of AIDS

III. Coping Skills

IV. Access to Resources

REVISED STUDY DESIGN

	Runaway males	Runaway females	Gay males
Intervention	75 (n=25)	75 (n=40)	75 (n=30)
Control	75 (n=60)	75 (n=65)	75 (n=50)

INTERVENTION CRITERIA

4 Coping skills training groups

3 Educational groups

2 Visits to the Door

1 Individual session

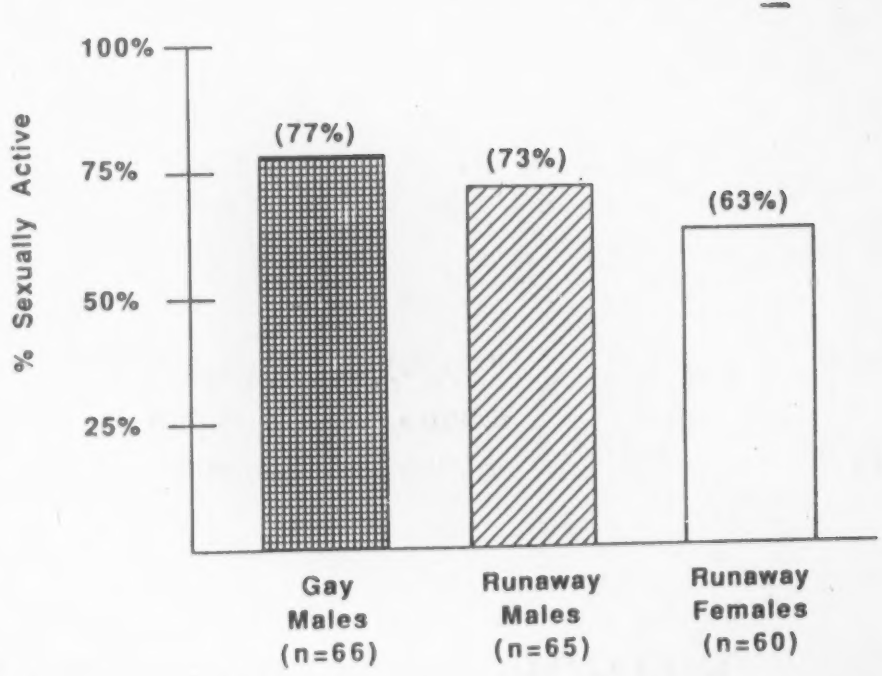
---

10 Total # of sessions

DEMOGRAPHICS

	Runaway males (n=66)	Runaway females (n=65)	Gay males (n=60)	Overall (n=191)
Age (mean)	15.9	15.7	16.7	16.0
Ethnicity				
Black	63.6%	63.0%	33.3%	53.9%
Hispanic	25.8%	26.1%	53.3%	34.5%
White/Asian	4.5%	3.1%	8.3%	5.7%
Bi-racial	6.1%	7.7%	3.3%	4.2%

PERCENTAGE SEXUALLY ACTIVE* IN THE LAST 3 MONTHS



* Sexual activity includes oral, anal, and vaginal intercourse; rimming for gay males

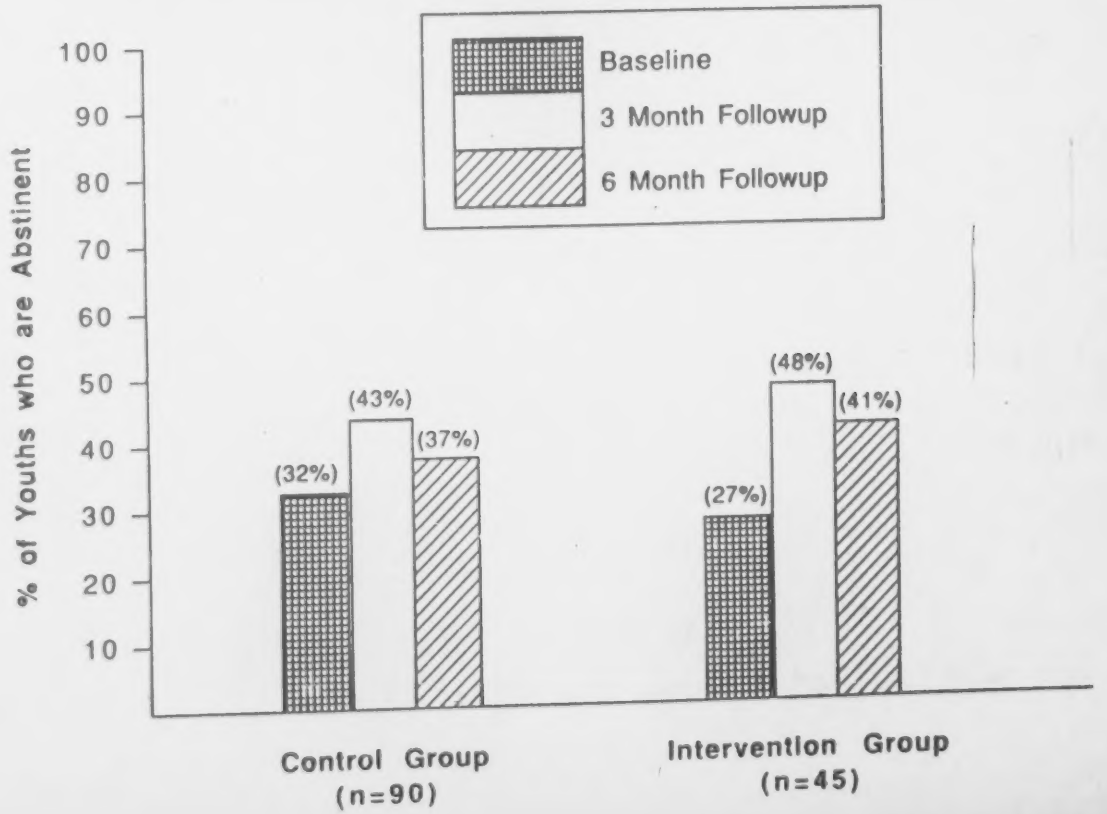
FREQUENCY OF SEXUAL BEHAVIOR DURING THE LAST 3 MONTHS

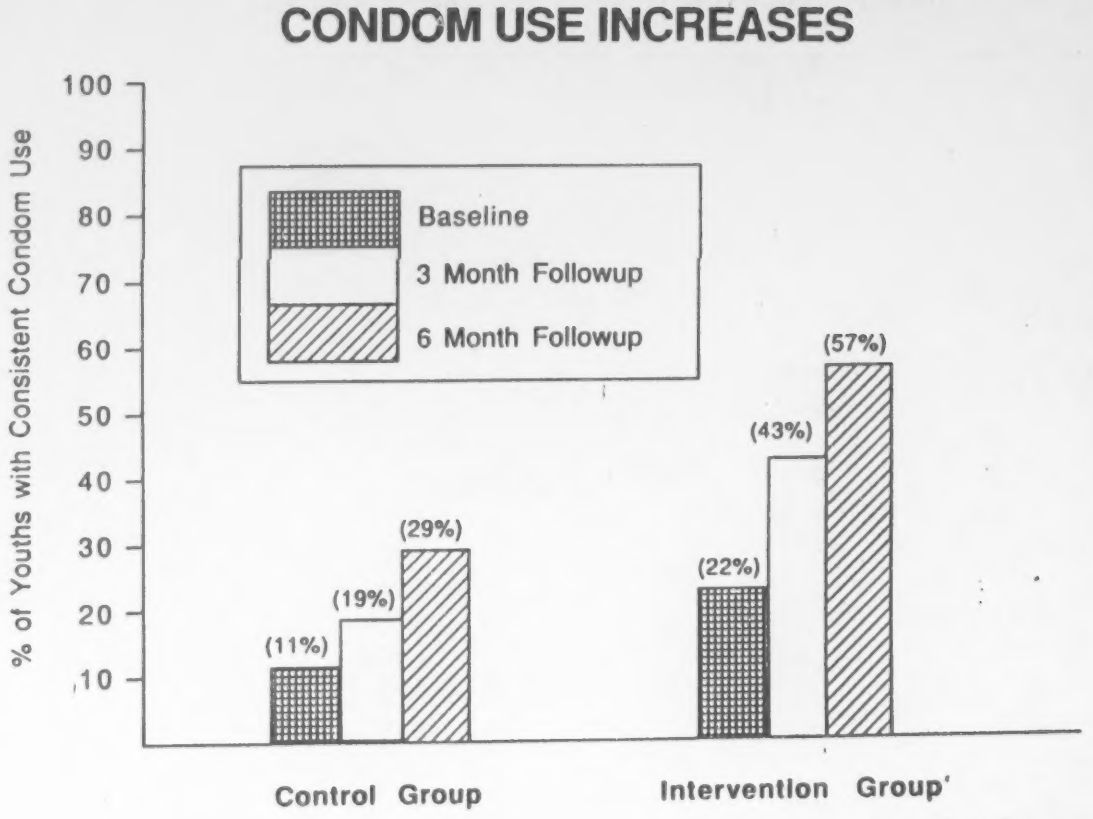
	Runaway males (n=66)	Runaway females (n=65)	Gay males (n=60)	Overall (n=191)
Mean number of preferred partners	4.8	1.7	4.1	2.7
Mean number of occassions with preferred partners	14.6	8.8	22.8	13.2
Bi-sexual activity	11.9%	14.3%	31.2%	19.2%

CONDOM USE DURING THE LAST 3 MONTHS AMONG THE SEXUALLY ACTIVE

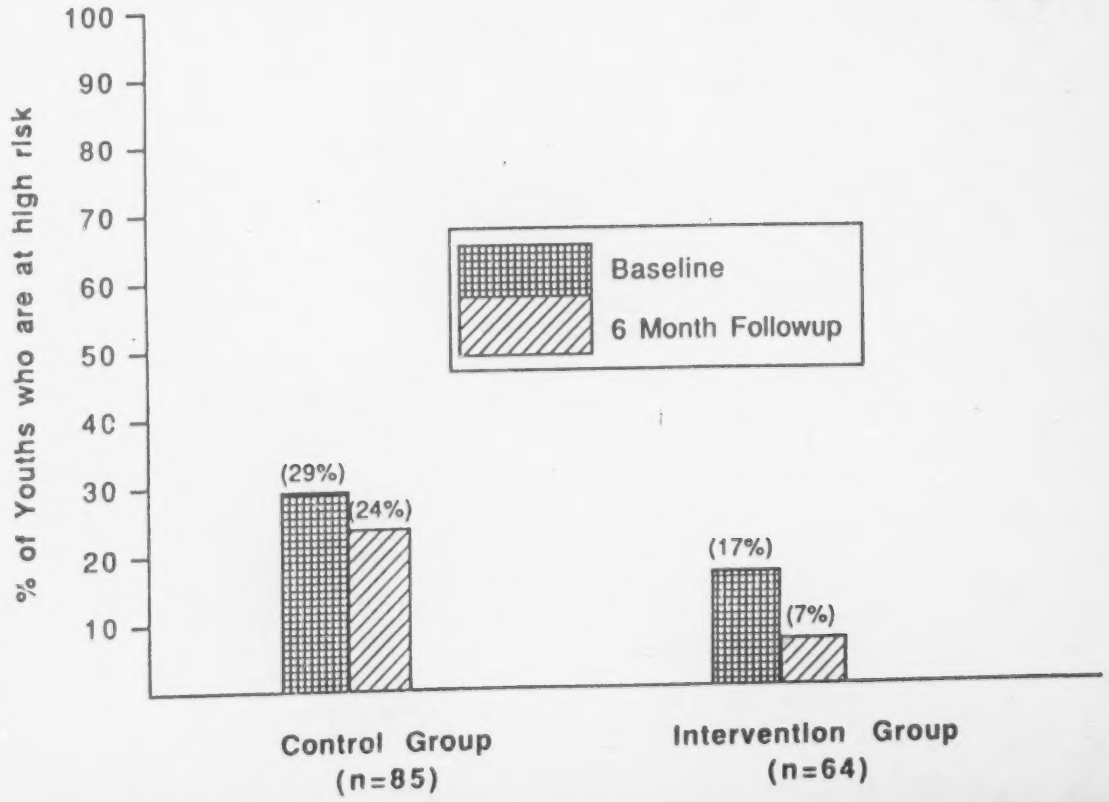
	Runaway males (n=66)	Runaway females (n=65)	Gay males (n=60)	Overall (n=191)
Never used condoms	38%	63%	44%	47%
Consistently use condoms	13%	15%	15%	14%

TEMPORARY INCREASE IN ABSTINENCE

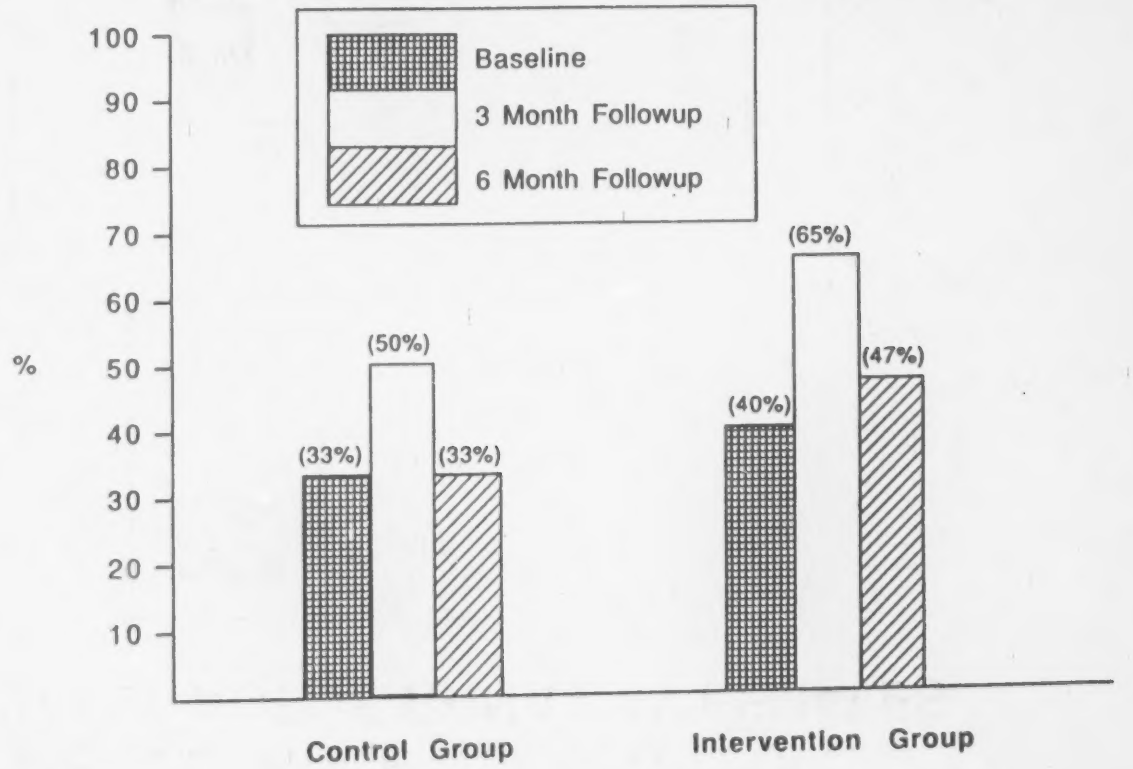



CONDOM USE INCREASES
% of Youths with Consistent Condom Use
100
90
80
70
60
50
40
30
20
10
Baseline
3 Month Followup
6 Month Followup
(11%)
(19%)
(29%)
(22%)
(43%)
(57%)
Control Group
Intervention Group

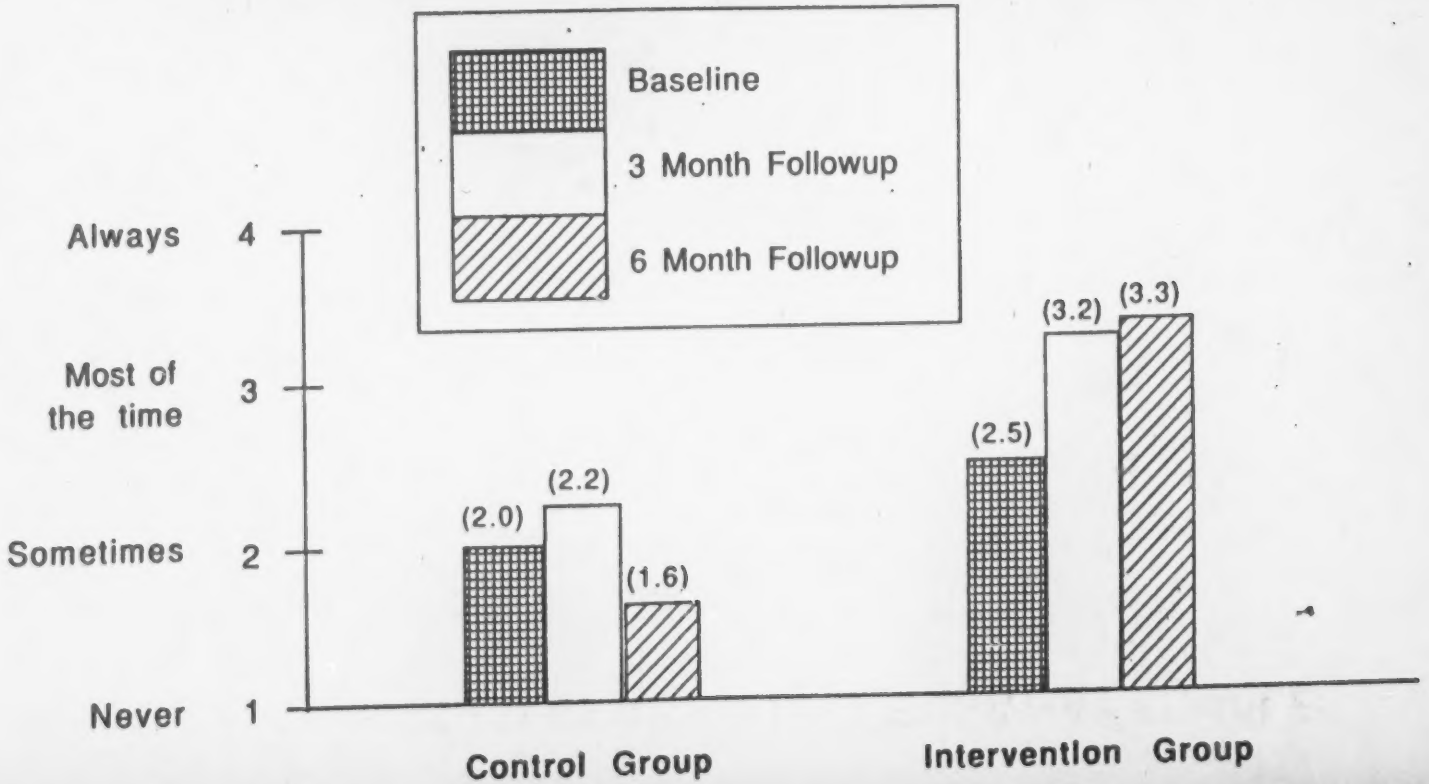
INTERVENTION REDUCES HIGH RISK PATTERN



SEXUALLY ABSTINENT RUNAWAY FEMALES



MEAN CONDOM USE SCORE OF SEXUALLY ACTIVE RUNAWAY FEMALES



RISK STATUS VARIABLES

RISK STATUS 1

Sexual Occasions and Condom Use

0: Sexually abstinent

1: Frequent condom use and 1-10 occasions

2: Frequent condom use and over 10 occasions

3: Infrequent condom use and 1-10 occasions

4: Infrequent condom use and over 10 occasions

RISK STATUS 2

Sexual Partners and Condom Use

0: Sexually abstinent

1: Frequent condom use and 1-2 partners

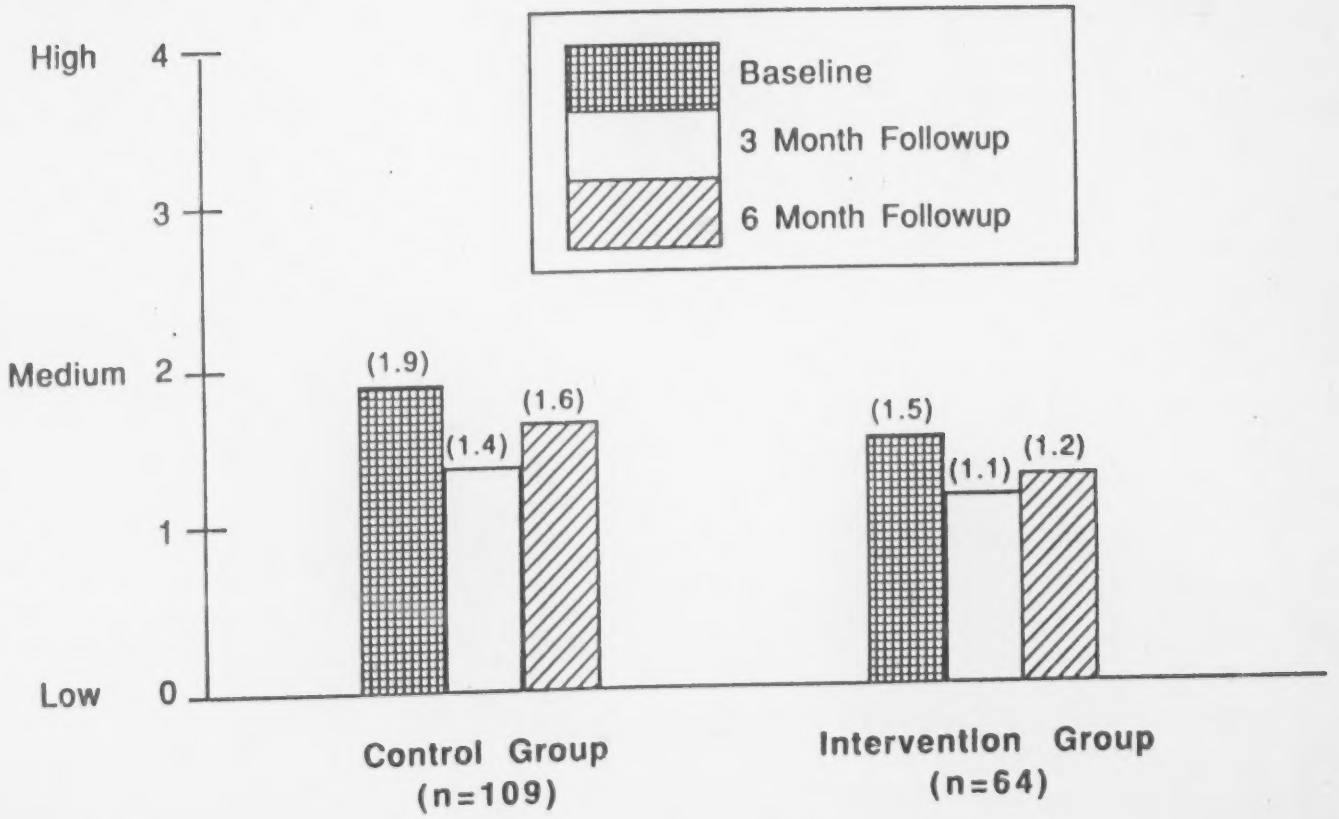
2: Frequent condom use and 3+ partners

3: Infrequent condom use and 1-2 partners

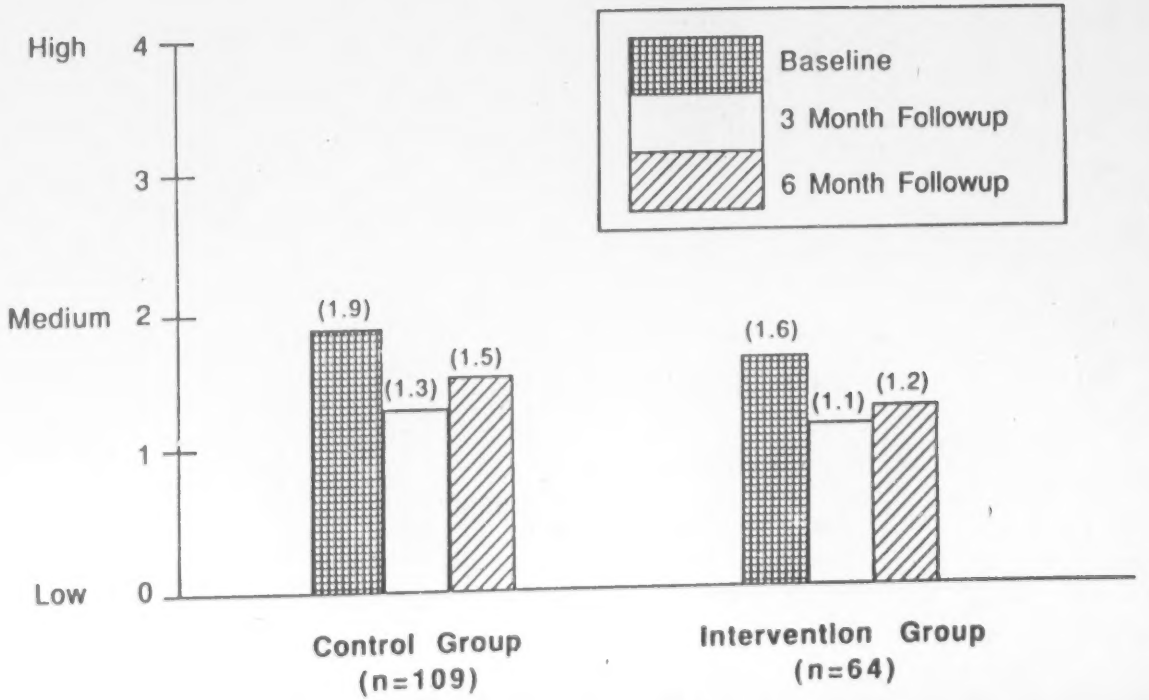
4: Infrequent condom use and 3+ partners

33-336 0 - 90 - 6

MEAN RISK STATUS 1



MEAN RISK STATUS 2



DRAFT

HIV INFECTION AMONG STREET YOUTH

OFFICE OF INSPECTOR GENERAL
Office of Evaluation and Inspections

AUGUST 1990

OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG) is to promote the efficiency, effectiveness, and integrity of programs in the United States Department of Health and Human Services (HHS). It does this by developing methods to detect and prevent fraud, waste, and abuse. Created by statute in 1976, the Office of Inspector General keeps both the Secretary and the Congress fully and currently informed about programs or management problems and recommends corrective action. The OIG performs its mission by conducting audits, investigations, and inspections with approximately 1,400 staff strategically located around the country.

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The purpose of this inspection is to determine the scope and nature of the problem of HIV infection among street youth. It provides an overview of the various issues presented by the epidemic, an understanding of how those issues are being addressed, and a set of recommendations for future action. The report was prepared under the direction of Mark R. Yessian, Ph.D., Regional Inspector General of Region I, Office of Evaluation and Inspections, and Martha B. Kvaal, Deputy Regional Inspector General. Participating in this project were the following people:

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HIV INFECTION AMONG STREET YOUTH

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OEI-01-90-00500

AUGUST 1990

EXECUTIVE SUMMARY

PURPOSE

The purpose of this inspection is to determine the scope and nature of the problem of HIV infection among street youth and of the services that address the problem.

BACKGROUND

AIDS is a major threat to adolescents. Although very few teenagers have developed AIDS, the number of 20- to 29-year-olds with AIDS suggests a high level of HIV infection (which causes AIDS) among teenagers. Some adolescents seem to be in more danger than others. They are "street youth," who have diverged from society's mainstream and have fallen through the safety net. Understanding the impact and future threat of HIV among street youth is critical for two reasons. First, recent medical developments in preventive AIDS therapies have made the early identification of infected street youth crucial for improving their chances of long-term survival. Second, a large number of street youth are fortunate enough to get off the streets. They may unknowingly bring the virus with them as they return to mainstream society. Preventing the spread of HIV among street youth thus becomes equivalent to preventing the spread of HIV among the general population.

FINDINGS

Both the risk and current rate of HIV infection are almost certainly higher among street youth than among adolescents in general.

Thousands of young people have been infected and street youth are in particular danger.

High infection rates among street youth are a predictable consequence of the risky behaviors that constitute their lifestyle.

Special needs of street youth compromise HIV prevention, testing, and treatment efforts.

Prevention: Basic survival needs of street youth overwhelm education efforts aimed at reducing high-risk behavior.

Testing: Youth workers often hesitate to test street youth for HIV because of the lack of proper counseling and available follow-up services.

Treatment: Traditional medical institutions and street youth don't mi..

The fight against HIV among street youth suffers from gaps in research on behavior change models, seroprevalence, and treatment protocols.

Behavior change models: Researchers and providers lack both basic information on street youths' sexual behavior and models for curtailing unsafe sex and drug use.

Seroprevalence: Because of insufficient data, attention and money may not be invested where they are most needed.

Treatment protocols: Manifestation of HIV disease in adolescents is an understudied phenomenon.

At the local level, categorical requirements and fragmented program structures weaken service delivery for street youth with or at risk of HIV infection.

Even when a range of services is offered, categorical requirements and other access barriers frequently render those services inaccessible to street youth.

Fragmentation of funding sources and different ideological approaches impose serious barriers to service delivery.

At the Federal level, the overall response to the problem of HIV infection among street youth is inadequately focused and coordinated.

The breach in coordination has especially severe ramifications for efforts involving HIV and street youth.

Street youth at risk of HIV infection seem to attract comparatively little attention from the Department, the public, traditional youth advocates, and Congress.

RECOMMENDATIONS

The Public Health Service

The Public Health Service, through the Centers for Disease Control, should conduct additional seroprevalence research to measure the scope of the epidemic among street youth.

The Public Health Service should collect baseline data on the sexual behavior patterns of street youth.

The Public Health Service, through the Alcohol, Drug Abuse, and Mental Health Administration, should conduct research on behavior change strategies designed to reduce the risk of HIV infection among street youth.

The Public Health Service should conduct research on the manifestation of HIV infection in adolescents and develop appropriate clinical protocols for treating youth who are infected.

The Office of Human Development Services and the Public Health Service

The Office of Human Development Services, in collaboration with the Public Health Service, should design and implement a strategy to curb HIV infection among street youth in five cities with large populations of street youth and high rates of HIV infection.

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INTRODUCTION

PURPOSE

The purpose of this inspection is to determine the scope and nature of the problem of HIV infection among street youth and of the services that address the problem.

BACKGROUND

Acquired immunodeficiency syndrome (AIDS) is a major threat to adolescents. Although only 513 people aged 13-19 have been diagnosed with AIDS[1], this figure drastically understates the level of human immunodeficiency virus (HIV) infection, which causes AIDS. The median incubation period for HIV appears to be about 10 years, and may be longer for adolescents than for adults.[2] This means that only those teenagers who were infected very young or who progressed from infection to AIDS very quickly are included in those 513 cases. Most people infected as teenagers will not develop AIDS before adulthood.

The number of AIDS cases reported in young adults provides a more accurate picture of the HIV epidemic among adolescents. Since 1981, 26,870 cases of AIDS have been diagnosed among 20- to 29-year-olds.[3] This group, many of whom must have been infected as teenagers, represents 20.3 percent of all AIDS cases reported to the CDC since the epidemic began. Compared to their older counterparts, 13- to 29-year-olds with AIDS are less likely to be white or male[4], meaning that the virus is spreading particularly fast outside the "traditional" risk group of white gay men. The problem is getting worse rather than better over time. More than 25 percent of all 13- to 29-year-olds who have developed AIDS were diagnosed in the last year.

Some adolescents seem to be at higher risk than others. These youth are the ones who have become displaced from society's mainstream and have fallen through the safety net. They are referred to as "disconnected," "disenfranchised," or "marginalized." Generally out of home, out of school, and out of work, they spend their days looking for food, shelter, recreation, and money on our urban streets. They revolve through our system of juvenile courts and jails, mental health facilities, foster care homes, and runaway shelters. We refer to this group as "street youth."

Street youth lead troubled lives. Data from runaway and homeless shelters indicate high rates among this population of physical and sexual abuse, emotional disturbance including depression and suicide attempts, and illegal drug use.[5] These problems can be either the cause or the result of life on the streets.

Our definitional boundaries of street youth are intentionally fluid. Strict age limits are undesirable because, unlike adolescents in stable residential and educational environments, street youth are likely to have peers, sexual contacts, and needle

sharing partners who are older than the traditional cutoff ages of 18 or 21. Definitions based on behaviors are equally problematic because of the variety of living arrangements and life histories among this population. For example, only a small percentage of street youth visit runaway shelters. A definition based on such visits would bar from consideration other youth in equally unfortunate situations and at equal risk for HIV infection. For purposes of this report, therefore, "street youth" refers to those adolescents and young adults who find their primary support systems and social structures on city streets rather than at home or in school.

The lack of firm inclusion criteria makes estimating the size of the street youth population difficult. However, all people who meet the Federal definition of homeless youth, and many who meet the Federal definition of runaway youth, could be considered street youth.[6] Estimates of the number of youth permanently on the streets fall between 100,000 and 300,000, with as many as 1,000,000 to 2,000,000 running away from home each year.[7]

Understanding the impact and future threat of HIV among street youth is critical for two reasons. First, recent medical developments in preventive AIDS therapies have made the early identification of infected street youth crucial for improving their chances of long-term survival. Second, a large number of street youth are fortunate enough to get off the streets. They may unknowingly bring the virus with them as they return to mainstream society. Preventing the spread of HIV among street youth thus becomes equivalent to preventing the spread of HIV among the general population.

Several operating divisions of the Department of Health and Human Services (DHHS) oversee activities relating to HIV and adolescents. The list includes the Office of Human Development Services (OHDS) and virtually every component of the Public Health Service (PHS): the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA); the Centers for Disease Control (CDC); the Health Resources and Services Administration (HRSA); the Indian Health Service (IHS); the National Institutes of Health (NIH); and the Office of Assistant Secretary for Health (OASH). All of these agencies except NIH and IHS target street youth specifically.

For instance, the National Institute of Mental Health, within ADAMHA, is funding research on the prevention and epidemiology of HIV among street youth. The OHDS provides technical and financial assistance to local agencies providing services to street youth through the Runaway and Homeless Youth Program and the Transitional Living Program. A more detailed description of Federal activities relating to HIV and street youth will be contained in a separate report.

METHODOLOGY

The methodology for this study is based on literature searches and interviews. The interviews consisted of: (1) formal telephone discussions with representatives of 13 national and 2 local organizations working on issues related to either adolescents or HIV; (2) formal telephone discussions with staff from 20 providers of health care and social services to street youth, representing the two providers serving the most street youth in each DHHS region of the country; (3) site visits to 3 additional service providers; (4) formal telephone and in-person discussions with 15 DHHS officials involved in adolescent or HIV-related research or programming; and (5) supplemental discussions with several researchers, doctors, and government officials. In addition, we requested and received written information from several components of DHHS documenting their efforts relating to HIV and street youth. A more complete explanation of the methodology is contained in appendix A.

FINDINGS

BOTH THE RISK AND CURRENT RATE OF HIV INFECTION ARE ALMOST CERTAINLY HIGHER AMONG STREET YOUTH THAN AMONG ADOLESCENTS IN GENERAL

Thousands of young people have been infected and street youth are in particular danger.

Data on seroprevalence (the prevalence of HIV infection in a given population) among some groups of youth are collected by three Federal agencies: the Centers for Disease Control (CDC), the Department of Defense (DoD), and the Job Corps, all of which conduct HIV antibody testing.[8] The CDC's best estimate is that 74,550 young people between the ages of 13 and 24 are currently infected, including those with AIDS. This is a rate of 1.8/1,000.[9] The rate varies fourfold between demographic groups, from 0.8/1,000 for females both 13-18 and 19-24 to 4.1/1,000 for 19- to 24-year-old males.

Results from other CDC studies and from DoD and Job Corps samples suggest that seroprevalence varies greatly according to geographic and demographic boundaries, with poor urban youth hit hardest by HIV. Some of the results from these testing programs are displayed in appendix B. From the DoD sample, it is clear that black and Hispanic males have become infected at far higher rates than military recruits in general. The Job Corps data show that HIV is spreading most rapidly in a few metropolitan areas. Additional data from CDC reveal that specific, high-risk populations of urban youth face future devastation unless a cure for HIV disease is found in time.

In our own survey of direct providers of services to street youth, we asked for estimates of seroprevalence among the client groups served. Three of the organizations surveyed conduct their own testing and track infection rates as a formal part of their program. The first is a youth shelter in a large southern city. Its clients are being tested anonymously, and are testing positive at a rate near 30/1,000. The second is another nonclinical program located on the west coast which tests only those clients who request it. Staff of this program report an infection rate of 110/1,000. The third is a clinical program that serves and tests high-risk youth referred by other service providers in a large east coast city. Over the past year, 30 of the 95 youth referred to the program have tested positive: a rate of 315/1,000.

High infection rates among street youth are a predictable consequence of the risk behaviors that constitute their lifestyle.

That many adolescents have already been infected with HIV should not come as a great shock. Teenagers often become sexually active and begin experimenting with drugs and alcohol before they have developed the skills necessary to moderate such

behavior. Over 60 percent of young Americans have sex before their 19th birthday. High rates of pregnancy and sexually transmitted diseases (STDs) indicate that most teen intercourse is unprotected.[10]

The behaviors that put street youth at risk for HIV infection are no different from behaviors that are risky for other adolescents, but are probably more frequent and occur in a different and riskier environment. Eighteen of the 23 service providers responding to our survey cited unprotected sex as the behavior most likely to place their clients at risk. Frequently mentioned contributing factors included sex with multiple partners, prostitution, and non-IV substance abuse.[11] In general, providers believe that high-risk sexual behavior is much more common among their clients than IV drug use. On average, respondents reported that slightly less than 8 percent of their clients engage in IV drug use. In contrast, 34 percent consistently engage in "survival sex," *i.e.*, sex in exchange for a broad range of items, including shelter, food, clothing, money, or drugs.[12]

In addition to behavior-related risks, physiological factors may further endanger adolescents. Researchers have noted that sexually active adolescents have higher rates of some STDs than do sexually active adults, suggesting that an adolescent's immunologic response to certain viruses may be weaker than that of an adult. One question under consideration by physicians is whether the factors that put adolescents at higher risk for STDs also affects their resistance to HIV infection.[13]

SPECIAL NEEDS OF STREET YOUTH COMPROMISE HIV PREVENTION, TESTING, AND TREATMENT EFFORTS.

Prevention: Basic survival needs of street youth overwhelm education efforts aimed at reducing high-risk behavior.

Education has long been used as a primary public health prevention strategy. In the context of HIV prevention, education efforts seem to have led to pronounced changes in behavior among adult gay men.[14] Among street youth, however, there is compelling evidence that education by itself is inadequate as a prevention technique.

Nearly all providers we spoke with reported remarkably high levels of knowledge among their clients about how to avoid HIV infection. Most have conducted tests of their clients' HIV knowledge before and after educational interventions. Estimates of the proportion of clients who now know which behaviors are risky ranged as high as 100 percent. Ten of 23 providers reported knowledge rates of 90 percent or higher, with an overall average of 81 percent. Nevertheless, providers consistently reported that knowledge has little effect on behavior. As described above, unprotected sex with multiple partners remains a common practice among street youth.

The reasons for this dissonance are complex and probably apply to most adolescents. But in the case of street youth, barriers to behavior change are even more profound and intractable. Providers reported that the need for food, shelter, or drugs displaces knowledge and fear of HIV risks. As one provider stated, "It [HIV prevention] all flies out the window when they don't have a place to sleep." As mentioned above, many street youth exchange sex for shelter or money, and we heard anecdotal evidence from providers in several cities that their clients are willing to pay more for sex without condoms. Forced to choose between safer sex and a higher "paycheck," street youth often opt for the money.

Without exception, the providers we talked with identified the shortage of accessible survival necessities -- such as housing, food, and drug treatment -- as a major impediment to successful prevention efforts. Only 2 of 23 providers surveyed believed that existing drug detoxification and rehabilitation services are adequate to meet clients' needs. Research and advocacy organizations concurred with the providers' assessments, stressing the need for basic social support services.

In the absence of an adequate supply of such basic services, most of these providers rely on prevention techniques that are not recognized as particularly effective, even by the those who employ them. Although all providers use pamphlets or other written materials and nearly all use educational videos, not one rated either of these methods as particularly effective for changing behavior or preventing infection.

Beyond the barriers to changing a street youth's behavior through education is another factor that is less frequently recognized but highly relevant to HIV prevention among this population: that of general health status and its relationship to transmission. Researchers believe that HIV proliferates when the immune system is active; consequently, a young person who is ill before she comes in contact with the virus may be more likely to become infected.[15] Malnutrition and use of drugs (including alcohol and tobacco) also compromise general health status,[16] and there is conclusive evidence that lesions associated with some STDs heighten the risk of transmission.

Health and mental health problems among street youth result from a number of factors, including poor nutrition and hygiene, as well as limited access to preventive and primary health care services. The relatively poor health status of most street youth has been well documented in a study conducted under the auspices of the Health Care for the Homeless project. The project's findings indicated that the street youth studied were twice as likely to suffer from a chronic disease than a control group of youth who were not homeless. Further, the percentage of homeless girls with STDs was over three times that of their non-homeless counterparts.[17] This suggests that the same behavior may place a street youth at significantly greater risk of HIV infection than her healthy counterpart who is living at home.

Testing: Youth workers often hesitate to test street youth for HIV because of the lack of proper counseling and available follow-up services.

Recent findings[18] about the ability of zidovudine (formerly AZT) to prolong the life of infected but asymptomatic persons have important implications for street youth. In order for youth to receive such therapy, however, their serostatus (*i.e.*, whether or not they have been infected) must be determined through testing.

Despite recognition of the potential value of early identification and treatment of infected youth, national organizations and service providers are highly ambivalent about the issue of testing. The source of this ambivalence is the inability of current testing sites to deal with the special needs of street youth. Five respondents from research and advocacy organizations expressed serious doubts about HIV testing because they questioned the resources available at or through test sites for youth who learn they are infected. Direct providers communicated the same concern: 13 of 18 responding felt that existing test facilities are not equipped to deal with youth.

By definition, street youth are without traditional social support networks that would facilitate access to counseling and other social services. Ideally, such services should be linked to the testing process, particularly when an infection is confirmed. In the absence of such support, a street youth may learn of her infection at a time when she has no place to sleep, no connection with family, and no immediate prospects for getting off the street. The counseling that accompanies HIV testing, therefore, must be tailored to recognize such circumstances.

Some providers reported suicidal ideation and actual suicide attempts to be common among street youth who learn that they are seropositive. There is some evidence that even youth who attend school and presumably have stronger support systems associate suicide with a positive HIV antibody test.[19] One provider we interviewed has documented the incidence of this behavior among its clients who are seropositive. Over a two-year period, 89 percent of these youth have either attempted suicide or engaged in unusual suicidal ideation. Although the link between positive test results and suicidal behavior is still being studied, anecdotal evidence such as this makes understandable the reluctance of some youth workers to recommend HIV testing for street youth.

This is not to say that providers unanimously oppose testing. Most either provide some testing services themselves or refer clients for testing at another site. Nevertheless, every provider in this category reported that the decision to test is made on a case-by-case basis. A number mentioned the availability of medical and social services for an HIV-positive youth as a primary factor in determining the suitability of testing.

Treatment: Traditional medical institutions and street youth don't mix.

The neglect and abuse suffered by street youth can make them distrustful and reluctant to engage in treatment. One researcher describes the difficulties homeless youth face in gaining access to services as follows: "Emotional problems and drug abuse problems, often in combination, exacerbate the difficulties of engaging and assisting them. They may be openly rejecting of services, particularly those that are not easily accessible to them. Thus, they are easy to disregard and ignore. . . ."[20]

Street youth are unlikely to seek out traditional institutions for care, particularly since many such programs actively reject them, considering them poor risks and too difficult to manage.[21] The direct service providers we surveyed, most of whom work exclusively with street youth, deal with distrust and alienation by employing extensive outreach programs. Eighteen of 23 reported using outreach workers to locate and engage street youth in services. But clinical care programs, many of which are hospital-based, are less likely to deploy resources for street workers to find infected street youth and engage them in care. Many may not have the resources to conduct active follow-up with youth who do not keep appointments or have difficulty adhering to a prescribed treatment regimen. Every outreach worker we interviewed described the problem of youth's alienation from institutional health care as critical in the overall HIV effort.

THE FIGHT AGAINST HIV AMONG STREET YOUTH SUFFERS FROM GAPS IN RESEARCH ON BEHAVIOR CHANGE MODELS, SEROPREVALENCE, AND TREATMENT PROTOCOLS.

Behavior change models: Researchers and providers lack both basic information on street youths' sexual behavior and models for curtailing unsafe sex and drug use.

Gaps exist in two areas of behavioral research. The first is purely descriptive. Although a number of studies have been conducted to assess the nature and frequency of youths' sexual behavior, many experts agree that there is limited knowledge about how teenagers decide to begin having sex and about the effects of family, school, and peer group experiences on sexual behavior.[22] Given the lack of data on the sexual behavior of adolescents in general, it is not surprising that little is known about factors affecting the sexual behavior of street youth in particular. Information about these factors could add significantly to the design of prevention programs aimed at modifying behaviors that place street youth at risk of HIV infection. The National Institute of Child Health and Human Development (NICHD) has prepared the "Survey on Health and AIDS Risk Prevalence" to gather this kind of information about sexual behavior in the general population. But this survey will not yield information directly applicable to street youth. The data gathered from a survey of this kind directed specifically at street youth could provide some of the baseline information necessary for the design of effective prevention programs for that population.

Research has also been sparse in the more general area of developing and evaluating the effectiveness of HIV prevention strategies for youth.[23] There is considerable debate among researchers and practitioners about the relative merits of various behavior change strategies in the context of HIV prevention among adolescents. Some evidence suggests that prevention programs in other health areas such as smoking and teenage pregnancy hold promise for adaptation to HIV prevention.[24] There is conflicting evidence about the effectiveness of peer-based education strategies. While some practitioners have found peer education to be popular with youth and useful in transferring information, others believe that peers lose their credibility once they are perceived as counselors.

There is no simple strategy for transferring to younger adolescents behavior change strategies that were effective with adult gay men. The need for modifying behaviors was strongly reinforced among older men by familiarity with peers who were sick and dying of AIDS. But because few infected youth show any symptoms, most street youth are unfamiliar with the shocking and visible signs of AIDS.

Seroprevalence: Because of insufficient data, attention and money may not be invested where they are most needed.

Because of the lag between infection and onset of symptoms, the President's Commission on the Human Immunodeficiency Virus Epidemic recommended in 1988 that researchers focus on HIV infection rates rather than AIDS case reports to measure the progress of the epidemic.[25] To date, no national, statistically reliable seroprevalence survey of street youth has been conducted. In fact, it is unclear whether such a survey is possible, given the relatively low number of subjects and their potential unwillingness to participate in such a study. The lack of accurate seroprevalence data, however, may have immediate and negative consequences for street youth in some cities and the organizations serving them.

A new CDC initiative, proposed for Fiscal Year 1991, provides an illustration of the problems facing program designers caused by lack of seroprevalence data. The Division of Adolescent and School Health, within CDC, plans to provide $1.5 million dollars to as many as six city health departments for establishing HIV prevention programs for out-of-school youth. To be eligible, cities must have reported at least 2,900 AIDS cases to the CDC by December 31, 1989. The eight qualifying cities are Chicago, Houston, Los Angeles, Miami, New York, Newark, San Francisco, and Washington, D.C.

But the number of total AIDS cases, as discussed above, may be a poor indicator of HIV prevalence, especially among street youth. By relying solely on total AIDS cases, CDC may be missing some cities with equally high rates or large numbers of cases of HIV infection among street youth in comparison to the eight cities just mentioned. For example, the list of eight cities with the highest current infection

rates among Job Corps applicants does not include Newark, Houston, Los Angeles or Chicago. Instead, Atlanta, Birmingham, Cleveland, and Baltimore are among the top eight. Alternatively, if *raw numbers* of infected Job Corps candidates are considered, the list of eight cities hit hardest by the epidemic includes Norfolk, Philadelphia, and St. Louis. Samples from the Job Corps applicant population, while not a perfect substitute, almost certainly give a better indication of the problem among street youth than total AIDS cases.

There are probably a number of reasons for the lack of reliable seroprevalence data on youth. In the course of our study we heard several possible explanations, including: 1) because of the small number of AIDS cases among adolescents during the early years of the epidemic, this group was not considered to be at risk; 2) the transient and secretive nature of this population makes them difficult to reach through traditional epidemiologic methods; 3) geographic and ethnographic differences among subpopulations of street youth make extrapolation and generalization to the population as a whole highly speculative; and 4) researchers and clinicians were concerned about the ethics of testing this population for a fatal and stigmatized disease in the absence of medical interventions and social support mechanisms.

An obvious use for additional seroprevalence data is resource allocation. In the coming years, budget constraints will likely force public and private managers to direct money and staff to very specific areas and people. AIDS case reports are of very limited utility in this regard, because they only reflect what was occurring a decade ago. On the other hand, HIV antibody status yields immediate information on the spread of the epidemic.

Treatment protocols: Manifestation of HIV disease in adolescents is an understudied phenomenon.

Complicating the problem of getting youth into medical care are unanswered questions about appropriate clinical protocols for treating youth. Each clinical provider we interviewed expressed concern about the dearth of knowledge regarding physiologic and pharmacologic aspects of treating HIV-infected youth. With the exception of adolescent hemophiliacs, adolescents have not been the subjects of systematic study in such areas as immune response, length of the HIV latency period, disease progression, or response to pharmacologic treatment.

As an example, until 1989 there were no adolescents from 13 to 17 years of age enrolled in the national clinical trials program.[26] By October, 1989, only 47 adolescents who were seropositive had been enrolled in trial protocols of zidovudine and other HIV-related therapies, and most were male hemophiliacs.[27] Weak representation of adolescents among clinical trial subjects can have important consequences: data collected during the trial process are used to determine appropriate dosage levels and schedules for subpopulations of patients. Since gender

and age-specific factors can affect dosage, effectiveness, and toxicity of drug therapy, more information about the pharmacodynamics (what drugs do to the body) and pharmacokinetics (what the body does to drugs) of various therapies as applied to adolescents could enhance the quality of available treatment.

Questions about disease progression and illness rate among infected adolescents also have critical implications for providing high-quality care. As one clinician who has recently begun treating HIV-positive youth in a clinic-based program told us, "I need to know more about which AIDS-related illnesses are likely to strike my patients and how those illnesses will manifest themselves in younger people. For example, are my patients likely to suffer from dementia, and if so, what will dementia look like in a teenager and how best can I treat it?"

This physician's concerns are supported by our own analysis of CDC's AIDS Public Information Data Set. We found that among people with AIDS, the rate of occurrence of at least five particular diseases differed significantly between teenagers and all other patients. As shown in table 1, teens with AIDS were less likely than others with AIDS to develop Kaposi's sarcoma and *Pneumocystis carinii* pneumonia, and more likely to develop extrapulmonary cryptococcosis, chronic intestinal cryptosporidiosis, and HIV wasting syndrome.

Table 1 – Occurrence of AIDS-Indicator Diseases in Teenagers with AIDS (TWAs) vs. All Others With AIDS (OWAs)

Disease	% of TWAs[a]	% of OWAs[b]
Kaposi's sarcoma	4.99	14.43**
Pneumocystis carinii pneumonia	47.72	58.07**
Extrapulmonary cryptococcosis	10.63	6.36**
Chronic intestinal cryptosporidiosis	4.56	2.21**
HIV wasting syndrome	15.18	11.35*

[a] n = 461; [b] n = 117,320; ** $p < .001$; * $p < .01$

Note: Data includes all cases reported to CDC through 12/31/89.
Data source: Center for Infectious Diseases, CDC, AIDS Public Information Data Set
Data analysis: Office of Inspector General

The data above suggest that age may be a critical factor in the progress of the disease, and reinforce the need for more extensive scientific inquiries about the natural history of AIDS among young people. The need for such research has been described by experts as "crucial in order to address, in a timely and comprehensive manner, the unique problems confronting adolescents with or at risk of HIV/AIDS."[28]

AT THE LOCAL LEVEL, CATEGORICAL REQUIREMENTS AND FRAGMENTED PROGRAM STRUCTURES WEAKEN SERVICE DELIVERY FOR STREET YOUTH WITH OR AT RISK OF HIV INFECTION.

Even when a range of services is offered, categorical requirements and other access barriers frequently render those services inaccessible to street youth.

Even the services that are offered to street youth on paper may be inaccessible in practice. Twenty of the 23 direct service providers in our survey reported significant barriers for their clients in accessing existing clinical and social services. The most frequently cited barrier (mentioned by 15 of the providers) is lack of ability to pay for needed services.

Not only do street youth lack money to pay for services, but they are frequently denied eligibility for Medicaid because they do not have Social Security Numbers or birth certificates and other required documentation. Sometimes the time and patience required to obtain the documentation and fill out forms and paperwork is simply beyond the capabilities of adolescents weary or afraid of dealing with the system.

Beyond the cost of care are other barriers, many of which are more complex than the payment issue. During each of our site visits, providers and health officials alike described a number of serious access barriers to programs that would otherwise appear to meet some of the special needs of street youth. The following are examples:

o *Consent Requirements:* Limitations on the rights of minors to consent to their own treatment can create formidable obstacles to care. The laws, regulations, and court decisions that govern consent are highly complex. There is little consistency among States: some permit minors to enroll themselves in mental health and drug rehabilitation programs, while others require parental consent. Virtually every State allows minors access to certain services associated with STD treatment but some insist on complicated and time-consuming legal procedures beforehand.[29]

o *Age Limits:* By our definition, street youth may range in age from early teens up to about 24 years old. After age 18, however, youths become ineligible for a number of critical services. For example, under the Department's Runaway and Homeless Youth Program, funds given to shelters may not be used to provide services to youths over age 18. Older street youth may be referred to adult shelters that are "wet" (*i.e.*, residents are currently using alcohol and other addictive substances). These shelters house a subpopulation of homeless people very unlike their own peer group. In many such cases, sleeping on the street is a more desirable option. Age may also serve as a barrier to drug therapy for youth who are already infected. One

project we visited was funded to provide zidovudine treatment only for seropositive youth age 18 or younger.

o *Length of Stay Limits:* Many programs funded to house street youth limit clients to 15- or 30-day stays. Designed to serve as temporary placements for emergency use, these shelters are increasingly faced with youth who have nowhere to go after this time has elapsed since for many street youth homelessness is not a temporary problem. Program managers from across the country expressed frustration with the absence of longer-term shelter programs. One project in Los Angeles has had a success rate of over 70 percent (measured by proportion of youths who do not return to street life and are able to support themselves) but only among youth who were offered structured shelter care for at least seven months.[30]

o *Other Conditions of Participation:* Many programs impose requirements that effectively exclude homeless youth from enrollment. For example, even when drug rehabilitation slots are available for street youth, other requirements may preclude their participation. At one site we visited, program staff reported the case of a highly motivated young girl who was accepted at a residential drug program well-known for its high rate of success. After clearing a morass of legal consent hurdles, they learned that the drug program's family-system approach requires that parents, spouses, siblings or "significant others" take an active part in the treatment process, both for immediate support purposes and continuity of care after discharge. Unfortunately, the young girl's family members were completely disengaged from her, and her peers (who might otherwise have served as significant others) were other homeless youth who were struggling with their own life problems. For want of a supportive partner, she was unable to complete the program.

Fragmentation of funding sources and different ideological approaches impose serious barriers to service delivery.

Given the broad and diverse range of problems that street youth have, the need for service coordination and collaboration among caregivers cannot be overstated. Yet during every site visit interview we conducted, the issue of service fragmentation was identified as a serious problem. To some degree, fragmentation is the result of separate funding streams and program designs, many of which are managed by DHHS. But poor coordination at the Federal level appears to be only one of a range of factors that splinter service delivery for street youth.

In some respects, the particular circumstances of service fragmentation are unique to the locality in which services are delivered. For example, because of their city's geography, providers in Los Angeles must deal with imposing transportation problems when attempting to design and coordinate a treatment plan for a street youth. Distance alone can serve as a serious barrier to a patient's compliance as well as to collaboration among care givers. But there do appear to be some factors that promote fragmentation no matter where the programs are located:

o *Separate Funding From a Variety of Sources:* Many providers expressed frustration with the classification of youth into categories such as "runaway," "prostitute," or "drug abuser." This results from funding programs that emphasize discrete problems as opposed to the interrelated needs of individuals. Exacerbating the difficulty is that sources of these "problem funds" are at different public and private levels. The following example, provided by a senior local public health official, may serve to illustrate the potential outcome of fragmented funding streams: Data gathered by the local public health department showed a significant increase in IV drug use in a certain sector of the city. At the same time, seroprevalence rates in that neighborhood began to increase, according to public hospital and clinic data. In separate actions, three different organizations (one drug treatment program, one youth service agency, and one community-based health clinic) applied for and received three separate grants from a Federal agency, a private foundation, and a State agency. All three applied for and received a major portion of overall funding designated for outreach workers. In the health official's words. "we had outreach workers tripping all over each other out there. In fact, we probably had more outreach workers on the streets than clients when all three programs were in full operation. At the same time, we went begging for outreach work in other parts of the city."

o *Competition Among Providers for the Same Funding:* In some cities that have been particularly hard hit by the epidemic, competition among providers for funding can be fierce. Many small, community-based agencies believe they are out-gunned by larger, more traditional institutions and consequently find themselves in even more intense competition with one another for a relatively small piece of the funding pie. This is not to say that such rivalries preclude any cooperation, but they clearly do not promote the kind of teamwork among providers necessary to maximize available resources.

o *Different Ideological Approaches:* Philosophical differences among providers can also be an impediment to coordinated care. The most frequently mentioned example of this phenomenon was in the area of drug treatment. Many drug rehabilitation programs are premised on a 12-step model that other service providers believe has limited relevance for homeless youth who are addicted to non-IV drugs. Providers told us that "even the language they [drug rehabilitation staff] use is foreign" to other social service workers.

Similarly, there are differences among service providers about the relative emphasis that should be given to case management and to collocation as methods of integrating the delivery of services to street youth. Through the case management approach, street youth in need of services are paired with youth workers who can help guide them through "the system." Many of those working in this field have viewed case management as a core service that is vital to any sustained effort

directed to street youth. Indeed, it has become a centerpiece of many demonstration and other project grants concerning street youth.

Yet other service providers, including many we met with, note that case management for street youth is frequently duplicated. They also note that it can be ineffective unless the case managers physically accompany their clients to appointments -- a practice that can put a severe strain on the supply of time and money. These providers suggest greater emphasis be placed on collocating HIV counseling, primary preventive medical care, and other key services under one roof. This approach, they emphasize, would minimize transportation problem and reduce the occurrence of missed appointments. However, it would require a considerable capital investment and could itself lead to some unnecessary duplication of services.

AT THE FEDERAL LEVEL, THE OVERALL RESPONSE TO THE PROBLEM OF HIV INFECTION AMONG STREET YOUTH IS INADEQUATELY FOCUSED AND COORDINATED.

The breach in coordination has especially severe ramifications for efforts involving HIV and street youth.

Coordination within DHHS is particularly important as far as HIV and street youth are concerned. The responsibility for virtually every piece of the fight against HIV is perceived to be shared by more than one Departmental agency. We asked Department officials to identify which part of the Department, if any, should have responsibility for nine separate functions related to combating HIV among street youth. For all but one function, at least five of the fourteen respondents identified more than one agency.[31] Nine thought that "determining what behaviors most commonly lead to the spread of HIV among the street youth population" should be a shared duty.[32] Eight thought that more than one agency should "design and evaluate programs to promote behavior change among street youth."[33] The only function that seems to lie clearly within a single agency's domain is "determining how many street youth are infected, and where they are." Twelve of the fourteen Department officials responding thought that this was CDC's responsibility. Still, five of the respondents named another agency instead of or in addition to CDC.

The National AIDS Program Office (NAPO) is supposed to "serve as the Public Health Service focus in coordinating and integrating efforts to prevent and control the occurrence and spread of HIV infection and AIDS."[34] Its ability to perform that duty may be hampered, however, by several circumstances. First, Departmental bodies which are not part of the PHS have little or no representation at NAPO-organized meetings. For instance OHDS, which sponsors several programs for street youth, does not have an official member on the PHS HIV Leadership Group, the PHS Executive Task Force on AIDS, the Panel on Women, Adolescents, and Children with HIV Infection and AIDS, or the Federal Coordinating Committee on the HIV Epidemic. Its absence from the last group is particularly surprising, because

the Federal Coordinating Committee goes beyond the PHS to include such agencies as the Environmental Protection Agency and the National Aeronautics and Space Administration.

Another limit to NAPO's effectiveness may be its emphasis on coordinating PHS programs that are directed at people with access to traditional educational and medical systems. One former NAPO employee told us that HIV-related activities aimed at street youth might be better coordinated through a body focused on the homeless rather than on the disease. Finally, NAPO's mandate appears to be limited to organizing meetings and "networking." It has no control over resource allocation or grant specifications. The decisions on particular programs and policies are ultimately left to the individual PHS components.

The exclusion of OHDS from the PHS coordinating process may explain the 1990 announcement of the Drug Abuse Prevention Program for Runaway and Homeless Youth.[35] This program is sponsored by OHDS's Family and Youth Service Bureau. The announcement acknowledges the link between substance abuse prevention and HIV prevention. But the only Federal agencies listed as sources of information on HIV and runaway youth are NIDA and the Office of Substance Abuse Prevention (OSAP). Applicants for this program could clearly also benefit from contact with the National Institute of Mental Health (NIMH), HRSA, and CDC.

Another example of a coordination gap is the existence of two Federally funded curricula on HIV prevention for high-risk youth. In 1987, NIDA's Community Research Branch contracted with Westover Consultants to produce and distribute the AIDS High Risk Adolescent Prevention curriculum. Also in 1987, CDC's Division of Adolescent and School Health awarded money to the National Network of Runaway and Youth Services to develop the "Safe Choices Guide: HIV and AIDS Policies and Prevention Programs for High-Risk Youth." Both are aimed at youth service organizations, one of which are funded directly by OHDS, and include basic educational information and suggestions for promoting safe behavior. We did not investigate thoroughly how or why both projects were funded simultaneously. There may be valid reasons for having two similar curricula, such as comparing their relative effectiveness. But it appears that they were not originally designed to complement each other, and on the surface there is no apparent need for both.[36]

The above discussion aside, there are parts of the Department that seem to be making progress in fighting the epidemic among street youth. For instance, national advocacy and research organizations applaud the Centers for Disease Control's concern for street youth and other adolescents at high risk of HIV infection. The CDC was the agency most often cited by these organizations as doing particularly well in this area. Both the Center for Prevention Services (CPS) and the Center for Chronic Disease Prevention and Health Promotion (CCDPHP) have been supporting HIV prevention efforts specifically targeted to out-of-school youth. In August 1989, CDC held an internal meeting to identify the most crucial components of HIV

prevention programs for out-of-school youth. In October 1989, the Deputy Director for HIV of CPS served as moderator to a PHS Bi-Regional Consensus Conference on HIV and runaway and homeless youth. The resulting recommendations from both gatherings addressed all the key issues raised in this report, including the need for provision of basic services to street youth and for coalition building between local service providers. Although the General Accounting Office recently stated that "CDC has accomplished relatively little in providing HIV education to out-of-school youth,"[37] CDC appears to have the knowledge, experience, contacts, and commitment to promote effective HIV prevention programs for street youth in the future.

Street youth at risk of HIV infection seem to attract comparatively little attention from the Department, the public, traditional youth advocates, and Congress.

Of the many groups who have been hit hard by HIV, street youth seem to have been the focus of relatively little publicity and political action. Concerted attempts to influence public policy on HIV-related issues remain largely the work of the adult gay community. Public compassion for people with AIDS seems to be directed mainly to those who are considered "innocent," such as newborns and recipients of infected blood products. For example, the only teenager with AIDS who has received national attention and sympathy was Ryan White, a hemophiliac who died in April 1990. As one Federal official told us, street youth have "fallen through the cracks. . . . The heartstrings go out to the young children -- not to the 13- or 14-year-old involved in prostitution."

Congressional interest in this population appears limited. Both the House and Senate introduced in 1989 versions of the *Young Americans Act*, which aims to increase Federal assistance to high-risk youth.[38] But as of June 1990, neither bill had seen action on the floor. The only committee to have held hearings on the matter of HIV and street youth recently is the Senate Committee on Governmental Affairs, whose mandate to investigate these issues is indirect at best.

Street youth may lack sufficiently strong voices in Washington. Two of the most well-known and respected advocacy groups for children's issues did not participate in the survey we conducted for this report. One referred us instead to a publication of theirs that was outdated and contained little information directly relevant to street youth. The other was willing to participate, but felt that they could add little in terms of opinions or insight beyond what was contained in their existing publications. Again, these publications were clearly focused on younger children in traditional settings, and had little to say with regard to street youth.

The general absence of focus on street youth may help to explain the Department's comparatively minimal response to the HIV epidemic in that population. When we asked our survey respondents to rate the overall response of the Federal government to the epidemic among adolescents, the ratings they offered were consistently lower in relation to street youth than to youth in general. This was reflected in the

responses of direct service providers, national organizations, and even HHS officials.[39]

In sum, street youth are easily invisible as a group, have no natural advocacy group, and do not generate the concern directed to other populations most at risk of HIV infection. It should not be surprising, therefore, that they have not become a primary focus of Federal policy makers' attention in the overall HIV effort. But their plight cannot be ignored, and their needs and requests are not outrageous. This is clear from the following excerpt of a letter written from a residential treatment facility by a 14-year-old HIV-positive girl to her doctor:

> "They were asking me do I have AIDS. . . . The counselor told the kids do not touch me and I can't touch them. You know how that makes me feel, I feel like I have no life. . . . I'm just writing this because I need somebody to love me and I need somewhere to be without everybody talking or asking me do I have AIDS. . . ."

RECOMMENDATIONS

THE PUBLIC HEALTH SERVICE

The Public Health Service, through the Centers for Disease Control, should conduct additional seroprevalence research to measure the scope of the epidemic among street youth.

In order to allocate resources efficiently, policy makers and program managers must have a clearer picture of where and to what extent street youth are becoming infected. Another reason to collect seroprevalence data is to demonstrate the severity of the problem. The long HIV incubation period means there will probably never be an AIDS epidemic among teenagers, no matter how many teens become infected with the virus.

Given the difficulties in generating valid national data on seroprevalence among street youth, it seems more appropriate to focus on locality-based data. Collecting such data is necessary if scarce resources for prevention and treatment are to be apportioned effectively. Because infection rates are likely to differ significantly between and perhaps even within metropolitan areas, a large number of sites must be selected for study.

In collecting and analyzing seroprevalence data on street youth, CDC should make full use of reliable data collected from other sources, both public and private. The CDC should make all data easily available to researchers and service providers. This data should be as detailed as possible without jeopardizing individual privacy rights.

The Public Health Service should collect baseline data on the sexual behavior patterns of street youth.

In response to the call by researchers and practitioners for more and better information on factors that encourage high-risk sexual behavior among street youth, the PHS should move quickly to collect this information. The data should be gathered from several metropolitan areas with large concentrations of street youth.

The Public Health Service, through the Alcohol, Drug Abuse, and Mental Health Administration, should conduct research on behavior change strategies designed to reduce the risk of HIV infection among street youth.

In the absence of a vaccine, only behavior change will slow or stop the spread of HIV. As mentioned previously, interventions developed for smoking cessation and pregnancy prevention may hold promise for HIV prevention efforts, but there has been little systematic evaluation of such efforts. In the meantime, resources have been channeled to traditional education-as-prevention efforts that clearly have limited

utility for street youth. Therefore, behavior change among street youth in particular should be a high priority for additional research efforts. What works for adolescents in general should not be presumed to work for street youth, because the physical demands and psychological effects of street life inhibit the success of traditional HIV risk reduction interventions.

The ADAMHA's research agenda should include modification strategies for all behaviors that place adolescents at risk, including substance abuse as well as high-risk sexual activity. It should continue the search for more effective treatment technologies for users of current drugs of choice such as "crack" cocaine. Because several ADAMHA divisions (including NIMH, NIDA, OSAP, and the Office of Treatment Improvement) have expertise in this area, a single unit should be designated to coordinate current and future research initiatives concerning street youth.

The Public Health Service should conduct research on the manifestation of HIV infection in adolescents and develop appropriate clinical protocols for treating youth who are infected.

Use of zidovudine and other therapies to delay the onset of symptoms among those infected with HIV represents a major breakthrough in treatment of the disease. But the use of these therapies for young people may be inhibited by a lack of information on the progress of the disease and the effects of such treatments on adolescents. The PHS should therefore further expand its current research efforts in both areas. Disease progression among adolescents should be studied more thoroughly and young people, especially young women, should be represented more broadly in the clinical trials of therapies designed to treat the disease. Data from trials can then be used to guide practitioners in developing treatment protocols and determining appropriate dosage levels, dosage schedules, and treatment of adverse reactions.

THE OFFICE OF HUMAN DEVELOPMENT SERVICES AND THE PUBLIC HEALTH SERVICE

The Office of Human Development Services, in collaboration with the Public Health Service, should design and implement a strategy to curb HIV infection among street youth in five cities with large populations of street youth and high rates of HIV infection.

Local-level service fragmentation and access problems discussed in this report cannot be resolved completely by Departmental efforts. But a combination of technical assistance, financial support, and removal of categorical barriers at the Federal level would create an environment in which service delivery reforms could be made.

We believe that a strategy of focusing on a small number of large urban centers with high HIV infection rates is warranted for three major reasons. One is that by

concentrating on specific localities, the particular type of services and service linkages needed can more readily be identified and implemented. A second is that by directing an intensified effort at cities with large populations of street youth and high rates of HIV infection, the Department can have a sizeable impact on the national problem. And finally, by carefully evaluating the effort, the Department and others can gain insights on how to respond more efficiently and effectively to the needs of street youth throughout the country.

Within the Department, OHDS is the most logical choice for lead agency since it has the most direct programmatic responsibility for the street youth population. The PHS, however, has been far more active in funding and overseeing HIV-related programs for youth and has a broader range of contacts with local health, education, and youth service organizations. Further, PHS (specifically CDC) would be best qualified to identify the five cities where seroprevalence rates and the number of street youth are highest. For these reasons, we recommend that OHDS collaborate closely with PHS in planning and implementing such an effort.

A number of researchers, practitioners, and non-profit organizations have done extensive, and in some cases, exemplary work in examining implementation problems and testing reform models. Staff of the Robert Wood Johnson Foundation as well as participants in the West Coast Scientific Symposium on Health Care of Runaway and Street Youth are two examples. Therefore, we strongly urge OHDS to ensure that experts from organizations like these participate formally in the planning and development of the five-city strategy.

To the maximum extent possible, the strategy should encourage local initiatives; facilitate the provision of basic services that address the survival necessities of street youth; make use of existing Federal programs such as the Runaway and Homeless Youth Program, the Transitional Living Program, and others; and foster the integration of services directed to these youth. This would be consistent with the Secretary's interest in promoting service integration.

In regard to the latter objective, we urge OHDS to give serious consideration to four steps that could be taken to reduce categorical program barriers at the service delivery level. Among the initiatives that should be considered are the following:

1. *The allowance of waivers to some categorical program requirements.* Such waivers could be helpful in developing service interventions which respond in a more efficient and effective manner to the multiple, interrelated needs of street youth. They might also provide a way to serve youth over age 18 if the alternative "adult" resources are not appropriate for older adolescents.

2. *The allocation of funds for local planning efforts and the requirement that further funding depend on demonstrated collaboration among service providers.* The Robert Wood Johnson Foundation has taken this approach recently with some

apparent success. The intent is to foster cooperation among a diverse group of agencies and professionals who may be otherwise inclined to work independently or competitively.

3. *The use of a single coordinating or "anchor" agency within each community.* The designation of a single community focal point for organizing the service interventions can facilitate the most efficient and effective use of the limited resources available. Ideally, such a focal point would be designated through the collaborative efforts of the local service providers.

4. *The collocation of some services for street youth.* As we have noted, street youth are often quite resistant to established health and social services. To the extent that such services are immediately accessible to them, their readiness to use them and their opportunity to benefit from them may be enhanced.

APPENDIX A

METHODOLOGICAL NOTES

The methodology for the study included the following:

1. *Literature review.* The study team conducted a literature review of popular, professional and government publications. We reviewed articles and reports on issues such as epidemiology; behavior modification models; HIV education, prevention, and intervention; adolescent health; HIV knowledge, attitudes, beliefs and behaviors; and clinical treatment.

2. *Federal survey.* The study team examined current Federal policy and actions on the issue of HIV infection among street youth through a review of Departmental documents and interviews with relevant staff in offices engaged in AIDS-related activities.

   In response to a formal request for information, eight Departmental offices provided a summary of ongoing activities relevant to HIV infection among adolescents for our review. Six other offices added supplemental information. We relied on the documents to formulate a profile of Departmental efforts and looked for signs of internal duplication and omissions.

   Following a review of these documents, we conducted interviews with 15 Federal employees who had significant experience with either HIV infection or street youth or both. The interviews garnered information on: the employees' perceptions of the strengths and weaknesses of Departmental efforts; suggestions for strengthening the Department's overall approach; coordination of activities within the Department; and mechanisms for sharing of information among offices and divisions.

   We analyzed the qualitative data collected in interviews with Departmental staff to identify barriers to communication and coordination within and among organizational components and ways to enhance collaboration. We reviewed Departmental efforts and strategies in the context of major research findings and lessons learned at the service delivery level.

3. *Research and advocacy organization survey.* Telephone interviews were conducted with officials from 2 local and 13 national independent organizations who perform research and provide advocacy services. The organizations selected either receive Federal funding for HIV-related activities, or were identified through the literature or word-of-mouth as playing a major role in this area.

The discussion guide used for the telephone interviews elicited information on such issues as coordination among advocacy and direct service organizations on the issue of HIV infection; their stance on HIV testing; their perceptions of the Federal response to HIV among street youth; and their ideas about successful prevention, testing, and treatment programs for this population.

4. *Direct service provider survey.* Information was obtained from direct service providers that serve street youth, through a telephone survey of 20 organizations and site visits to 3 selected providers. The Office of Human Development Services provided a list of candidates for the survey. From this list we selected 23 organizations on the basis of caseload size and geographical diversity (each region of the country yielded at least 2 participants). The site visits took place in three major urban areas with a relatively large population of street youth and a selection of programs that serve them.

   We conducted the telephone interviews with the executive directors of these organizations, or their designees. A discussion guide was used to ask them about issues that affect service delivery for street youth; lessons learned from experiences with service delivery; and perceptions of Federal efforts. A protocol, incorporating the issues covered in the telephone interview and elaborating upon them, was used for the site visits.

   The telephone interviews and site visits were used to develop profiles of programs that are providing innovative services, to create an inventory of positive and negative lessons learned at the service delivery level, and to identify areas of consensus regarding opportunities to improve Departmental efforts.

A list of participating offices and organizations follows:

Federal offices responding to a formal request for information: Alcohol, Drug Abuse, and Mental Health Administration; Centers for Disease Control; Food and Drug Administration; Health Resources and Services Administration; Health Care Financing Administration; National AIDS Program Office; National Institutes of Health; and Office of Human Development Services.

Offices providing supplemental information: Bureau of Prisons; Indian Health Service; Job Corps; Office of Assistant Secretary of Defense for Health Affairs; Office of Disease Prevention and Health Promotion; and Office of Minority Health.

National and local research and advocacy organizations: American Foundation for AIDS Research; Association for the Care of Children's Health; Boston AIDS Consortium; Center for Population Options; National AIDS Network; National Coalition of Advocates for Students; National Coalition of Hispanic Health and Human Services Organizations; National Commission on Correctional Health Care; National Education Agency/Health Information Network; National Minority AIDS

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Council; National Network of Runaway and Youth Services; National Organization of Black County Officials; Planned Parenthood (of Washington, D.C.); Society for Adolescent Medicine; and U.S. Conference of Mayors.

Direct service organizations: Adolescent AIDS Program, Bronx, NY; Avance Human Services, Los Angeles, CA; Bridge Over Troubled Waters, Boston, MA; Casa Shelter YMCA, Dallas, TX; Comitis Crisis Center, Aurora, CO; Covenant House, Miami, FL; The Door, New York, NY; Gay and Lesbian Community Service Center, Los Angeles, CA; Janice Youth Programs, Portland, OR; L.A. Children's Hospital, Los Angeles, CA; L.A. Network, Los Angeles, CA; Larkin Street, San Francisco, CA; Middle Earth Unlimited, Austin, TX; Neon Street Shelter, Chicago, IL; New Beginnings, Lewiston, ME; Sasha Bruce Youthworks, Washington, DC; Streetwork Project, New York, NY; Synergy House, Parkville, MO; Teen Living, Chicago, IL; Volunteers of America, Denver, CO; Youth Care, Seattle, WA; Youth Emergency, Philadelphia, PA; and Youth Emergency Shelter and Services, Des Moines, IA.

APPENDIX B

RESULTS OF SELECTED GOVERNMENT-SPONSORED HIV ANTIBODY TESTS

Testing Agency	Population (and Age Range When Available)	Location	HIV + (Rate per 1,000)
Defense Dept.[40]	All recruits, 17-20	National	0.2
	Hispanic males, 17-20	National	1.2
	Females, 17-20	W. S. Central Region[43]	1.37
	All recruits, 21-25	National	1.6
	Males, 21-25	South Atlantic Region[44]	3.78
	Black males, 21-25	National	6.2
Job Corps[41]	129,754 recruits	National	3.88
	647 recruits	San Francisco	13.91
	1,078 recruits	Miami	12.98
	5,275 recruits	New York City	10.42
CDC[42]	Homosexual men at Sexually Transmitted Disease clinics, 18-25	Not Available	100 - 700
	IV drug users in treatment, 18-25	New York City and Puerto Rico	500 - 600
	IV drug users in treatment, 18-25	Outside east coast	< 50
	Homeless youths	New York City	70

APPENDIX C

ENDNOTES

1. Centers for Disease Control, *HIV/AIDS Surveillance Report*, May 1990. Figures through April 30, 1990. Teenagers represent less than 0.4 percent of the total number of AIDS cases.

2. Centers for Disease Control, *Strategic Plan for the Prevention of Human Immunodeficiency Virus (HIV) Infection: 1990 and Beyond (Draft)*, Centers for Disease Control, 1990. For adolescent vs. adult incubation period, see Goedert, J.J., et al., "A Prospective Study of Human Immunodeficiency Virus Type 1 Infection and the Development of AIDS in Subjects with Hemophilia," *New England Journal of Medicine* 321(17):1141-1148, 1989.

3. Centers for Disease Control, *HIV/AIDS Surveillance Report*, May 1990. Figures through April 30, 1990.

4. Ibid. Whites constitute 57.5 percent of people with AIDS over 30, but only 52.2 percent of people with AIDS between 13 and 29 years old. Males constitute 91.5 percent of people with AIDS over 30, but only 87.4 percent of people with AIDS between 13 and 29 years old.

5. See, for example, U. S. General Accounting Office, *Homelessness: Homeless and Runaway Youth Receiving Services at Federally Funded Shelters*, HRD-90-45, December 1989.

6. A runaway youth is a person under 18 years old who absents himself or herself from home or place of legal residence without the permission of parents or legal guardians. A homeless youth is a person under 18 years old who is in need of services and without a place of shelter where he or she can receive supervision and care. See *Federal Register* 55(44):8086, March 6, 1990.

7. Figures from the National Network of Runaway and Youth Services, cited in U. S. General Accounting Office, *AIDS Education: Programs for Out-of-school Youth Slowly Evolving*, HRD-90-111, May 1990, p. 2.

8. The Department of Defense, whose test results are often cited as evidence of the infection rate among young Americans, has actually witnessed a decline in the incidence of HIV antibodies among applicants since 1985. This may be due, however, to self-selection bias caused by knowledge of HIV testing requirements and by recent publicity surrounding DoD's policy of excluding homosexuals from military service. Furthermore, the military is not likely to attract many street youth. Unlike military recruits, 97 percent of all Job Corps entrants are under 21 years old and are

primarily from low-income families and urban settings. Although the Job Corps sample certainly taps the street youth population more regularly than the military sample, it too may underestimate the true incidence of HIV among street youth. The Job Corps's testing requirements are also well known, and the Corps tests only those street youth who are motivated to enter a strictly regimented program.

9. Response to OIG request from Deputy Director (HIV), Centers for Disease Control, May 1990. These estimates are derived from seroprevalence data gathered at 26 sentinel hospitals, which are part of CDC's efforts to determine the progress of the epidemic nationwide. The CDC was unable to provide any demographic information other than age range and sex to accompany this estimate.

10. Brooks-Gunn, J., Boyer, C.B., and Hein, K., "Preventing HIV Infection and AIDS in Children and Adolescents: Behavioral Research and Intervention Strategies," *American Psychologist* 43(11):958-964, 1988.

11. Non-IV substance abuse, while not considered risky for HIV transmission in itself, is thought to stimulate sexual activity and interfere with the cognitive functioning necessary for safer sex.

12. This is a weighted average, with weight added in proportion to the number of clients served.

13. Personal communication with Diane Sondheimer, National Institute of Mental Health, March 1990.

14. Becker, M.H., and Joseph, J.G., "AIDS and Behavioral Change to Reduce Risk: A Review," *American Journal of Public Health* 78(4):394-410, 1988.

15. National Institute on Drug Abuse, *AIDS High Risk Adolescent Prevention Project: Participant's Manual*, n.d., pp. 2-10.

16. Ibid.

17. Wright, J.D., "Poverty, Homelessness, Health, Nutrition and Children," unpublished paper delivered at conference on *Homeless Children and Youth: Coping with a National Tragedy*, Washington, D.C., May 1989.

18. National Institute of Allergy and Infectious Diseases, "Recommendations for Zidovudine: Early Infection," *JAMA* 263(12):1606-1609, 1990.

19. Goodman, E., and Cohall, A.T., "Acquired Immunodeficiency Syndrome and Adolescents: Knowledge, Attitudes, Beliefs, and Behaviors in a New York City Adolescent Minority Population," *Pediatrics* 84(1):36-42, 1989.

20. Athey, Jean, "HIV Infection and Homeless Adolescents," unpublished manuscript, 1990, p. 7.

21. Ibid.

22. Brooks-Gunn, J., and Furstenberg, F.F., "Adolescent Sexual Behavior," *American Psychologist* 44(2):249-257, 1989.

23. D'Angelo, L.J., and Sondheimer, D.L., "Adolescents and HIV Infection: Struggling Not to Be Forgotten," *Pediatric AIDS,* in press. See also the Office of Technology Assessment Staff Paper, *How Effective is AIDS Education?*, 1988.

24. Flora, J.A., and Thoresen, C.E., "Reducing the Risk of AIDS in Adolescents," *American Psychologist*, 43(11):965-970, 1988.

25. Watkins, J.D., et al., *Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic*, 1988, p. 3.

26. Pediatric AIDS Coalition, *1990 Legislative Agenda*, p. 12.

27. Personal communication with Diane Sondheimer, National Institute of Mental Health, May 1990.

28. Ibid.

29. English, A., "Adolescents and AIDS: Legal and Ethical Questions Multiply," in Quackenbush, M., Nelson, M., and Clark, K., *The AIDS Challenge, Prevention Education for Young People*, Santa Cruz, CA: Network Publications, 1988.

30. Yates, G., Testimony before the Little Hoover Commission on California State Government Organization & Economy, December 13, 1989. Also personal communication with Gary Yates, March 1990.

31. For the purposes of this question, we considered each major component of the Public Health Service plus OHDS and HCFA to be a separate agency. Subcomponents such as the National Institute of Mental Health and the National Institute on Drug Abuse were not considered separate agencies.

32. The particular agencies named most often were CDC (11 mentions), ADAMHA (5 mentions), and NIH (5 mentions).

33. Here the most commonly cited agencies were CDC (10 mentions), ADAMHA (7 mentions), HRSA (4 mentions), NIH (4 mentions), and OHDS (3 mentions).

34. National AIDS Program Office, unpublished document, June 1989.

35. *Federal Register* 55(92):19832-39, May 11, 1990.

36. Now that both have been completed and are being implemented across the country, OHDS is making efforts to ensure coordination between agencies and contractors.

37. U.S. General Accounting Office, *AIDS Education: Programs for Out-of-School Youth Slowly Evolving*, HRD-90-111, May 1990, p. 1.

38. H.R. 1492; S. 1911.

39. We asked for ratings of the overall response on a scale of 1-10, with 1 meaning poor and 10 meaning excellent. The mean responses were as follows: From direct service providers, 2.4 for street youth and 3.4 for youth in general; from research and advocacy organizations, 2.4 for street youth and 4.0 for youth in general; from DHHS officials, 3.7 for street youth and 5.9 for youth in general.

40. Response to OIG request from Office of Assistant Secretary of Defense for Health Affairs, Department of Defense, March 1990. Data collected between October and December 1989.

41. Response to OIG request from Director, Office of Job Corps, Department of Labor, March 1990. Data includes all tests conducted between October 1, 1987 and October 31, 1989.

42. For homosexual men and drug users, see Public Health Service, draft of *Year 2000 National Health Objectives*, p. 13-7. These data were collected in 1987. Homeless youth survey results obtained from Center for Infectious Diseases, Centers for Disease Control, May 1990. The dates of data collection are unknown.

43. This region includes Arkansas, Louisiana, Oklahoma, and Texas.

44. This region includes Delaware, Maryland, the District of Columbia, Virginia, West Virginia, North Carolina, South Carolina, Georgia, and Florida.

United States General Accounting Office

GAO

Report to the Chairman, Committee on Governmental Affairs, U.S. Senate

July 1989

AIDS EDUCATION

Staffing and Funding Problems Impair Progress

GAO/HRD-89-124

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-230539

July 28, 1989

The Honorable John Glenn
Chairman, Committee on
Governmental Affairs
United States Senate

Dear Mr. Chairman:

This letter responds in part to questions raised in your September 26, 1988, request concerning oversight of programs managed by the Centers for Disease Control (CDC) to prevent the spread of the human immunodeficiency virus (HIV), which causes acquired immunodeficiency syndrome (AIDS). As part of our ongoing review of HIV education and prevention efforts,[1] you asked us to obtain information on CDC's management of prevention funding to state and local health departments.

In 1989, CDC planned to provide about $144 million in funding support to state and local health departments to operate HIV prevention programs. The health departments target health education and risk reduction messages to persons at increased risk of infection, such as homosexual men, intravenous drug users, and minorities.

Without a vaccine or cure on the horizon, AIDS prevention programs are critical because they are the only public health tool available to reduce the potential medical and social costs of the HIV epidemic. While education programs have been expanding over the past few years, information about their implementation and effectiveness is still limited.

Background

The HIV epidemic is a national public health threat of potentially catastrophic proportions. Through April 1989, CDC reported over 94,000 cases of AIDS, of which over 54,000 persons were known to have died. The Public Health Service predicts that as many as 1.5 million Americans may already be infected with HIV, and epidemiological research suggests that more than 50 percent of those infected will develop AIDS.

[1] At your request, we addressed education efforts to reach high-risk persons through counseling and testing programs (AIDS Education: Issues Affecting Counseling and Testing Programs, GAO/HRD-89-39, Feb. 3, 1989). In this report, we examine staffing and funding of health education and risk reduction programs. Our ongoing work focuses on education aimed at school and college-aged youth and intravenous drug users. We also reported on CDC's general education program (AIDS Education: Activities Aimed at the General Public Implemented Slowly, GAO/HRD-89-21, Dec. 16, 1988).

CDC, the lead federal agency for AIDS prevention programs, assigned responsibility for reaching persons at increased risk of infection to its Center for Prevention Services (CPS). CPS funds these AIDS prevention programs principally through cooperative agreements with state and local health departments. Between 1985 and 1989, funding for programs targeted to persons at increased risk grew from $13.5 million to $184 million,[2] almost doubling annually.

State and local health departments are responsible for managing and operating the cooperative agreements, which fund a wide variety of prevention activities, including health education and risk reduction programs. These activities include

- HIV counseling and testing for clients at sexually transmitted disease and drug abuse clinics;
- telephone hotlines;
- media campaigns, such as radio and television public service announcements; and
- diverse efforts by community-based organizations, such as teaching women who are intravenous drug users how to clean needles, educating persons at soup kitchens, and sponsoring HIV awareness days for low-income blacks and Hispanics.

Objectives, Scope, and Methodology

In response to your request, we focused this review on

- CPS actual and targeted staffing levels for managing HIV cooperative agreements,
- oversight of federally funded HIV prevention activities, and
- problems in the funding cycles of AIDS prevention cooperative agreements.

We conducted our work at CDC headquarters in Atlanta, where we interviewed program officials responsible for managing AIDS activities. We also reviewed financial, staffing, monitoring, and other CDC records associated with these activities. Although we did not conduct detailed reviews of AIDS prevention programs in state and local health departments, we obtained the views of state officials by interviewing directors

[2]About $144 million is budgeted for state and local health departments, and the remainder includes funds for national organizations, such as the U.S. Conference of Mayors and the National Hemophilia Foundation.

of state health departments at a meeting of the Association of State and Territorial Health Officials.

Our work was performed primarily between September 1988 and January 1989 in accordance with generally accepted government auditing standards.

Difficulties in Meeting Staffing Targets

The HIV epidemic has resulted in the Center for Prevention Services taking on new and growing responsibilities. CPS's funding for cooperative agreements with state and local health departments for HIV prevention increased from about $25 million in 1986 to about $144 million in 1989.

Under the cooperative agreements for AIDS prevention, CPS is responsible for providing general guidance and technical assistance regarding activities the state and local health departments should carry out. CPS is also responsible for monitoring and evaluating health department activities to help ensure effective use of federal HIV prevention funds.

CPS officials believe that they need to hire additional staff to oversee this rapid expansion in federal funding and to recruit staff with different skills. CPS has traditionally been responsible for funding and coordinating state health department efforts to control sexually transmitted diseases, such as syphilis and gonorrhea. Because these diseases can be cured, programs have emphasized clinical treatment and investigation of cases, with education and efforts to modify sexual behavior playing a minor role.

AIDS, in contrast, is currently incurable and can be controlled only by preventing transmission. Moreover, HIV prevention programs have had to address new and relatively unproven educational approaches, such as how to motivate long-term changes in sexual and drug-using behaviors that spread HIV. As a result, CPS officials said that technical assistance to state health departments for HIV prevention programs would require hiring staff with specialized skills, such as expertise in behavioral sciences and in community health education methods.

CPS was first provided staff for HIV prevention programs in 1985 with an allocation of 13 full-time staff. By February 1988, 40 full-time staff[3] at CPS were allocated to work on HIV prevention programs. Even with this

[3]This does not include 35 field staff assigned to state and local health departments.

expansion, CPS concluded that it did not have enough staff to keep up with its growing responsibilities.

Staffing problems continued through 1988.[4] On four occasions in 1988, the Center for Prevention Services officially requested more staff. CDC was unable to fully meet these repeated requests, however, because of agencywide staffing constraints. For example, in October 1988, CPS requested 67 additional staff, but CDC approved only 24. CPS also encountered difficulties in filling even approved positions because of problems in hiring individuals with the requisite specialized skills. Not until September 1988, for example, had CPS hired staff with behavioral science or health education expertise to provide technical assistance for developing health education and risk reduction programs.

Agency officials reported that in 1989, staffing shortages continue to hamper CPS's ability to accomplish its AIDS oversight and technical assistance responsibilities effectively. In February 1989, CPS requested 65 additional positions, which were all approved by CDC. Because of insufficient funds to pay for these positions, however, CPS will be able to fill only 35 of the 65 positions.

As of May 31, 1989, CPS had 93 full-time staff working on HIV programs as well as approval and budget to hire 33 more by the end of fiscal year 1989. If all these positions are filled at that time, CPS officials believe they will still need about 30 more positions to carry out their AIDS responsibilities.

Staffing Shortages Have Hindered Key Monitoring Activities

CPS is responsible for providing general guidance to and monitoring of health departments to help ensure effective use of federal HIV prevention funds. This responsibility includes

- providing health departments with technical assistance in planning, operating, and evaluating targeted education activities;
- assisting health departments in evaluating the overall effectiveness of program operations; and
- developing and disseminating information on HIV prevention program activities and evaluation methods that are effective.

[4]We testified in June 1988 (Issues Concerning CDC's AIDS Education Programs, GAO/T-HRD-88-18, June 8, 1988) that staff shortages hampered CDC's ability to manage its AIDS activities effectively.

Several state officials told us that they were not receiving the technical assistance they needed from CPS to help them implement their AIDS prevention programs. They particularly needed help in designing programs that motivate individuals to change their sexual and drug-using behaviors.

State officials also reported a need for more federal technical assistance in developing Knowledge, Attitude, Beliefs and Behavior (KABB) baseline data. These data measure the community's knowledge about HIV and the extent to which behaviors that spread HIV are practiced. Health departments can use these data to identify gaps in knowledge, establish priorities for HIV education activities, and set objectives for increasing knowledge and reducing risky behavior. Follow-up KABB surveys can then provide a basis for CDC and the health departments to measure program effect.

Beginning in April 1986, CDC provided funds to 55 state and local health departments nationwide to conduct KABB surveys relating to the general public and high-risk groups. By March 1987, CDC required the health departments to use the survey data to develop measurable program objectives. The departments were specifically asked to evaluate observed changes in knowledge and behavior patterns.

In spite of CDC's requirements, as of September 1988, many health departments had not gathered and used baseline data to manage their HIV education programs. (See table 1.) In particular, CDC records indicated that several states and territories with large numbers of AIDS cases had not completed KABB surveys or used available KABB data to set program objectives.

Table 1: Progress of 55 Health Departments in Completing and Using KABB Data (Sept. 1988[a])

Group	Number of health departments that have	
	Completed KABB surveys	Used KABB data to set objectives
General public	45	30
Homosexual and bisexual men	33	13
Intravenous drug users	18	8

[a]Most recent data tabulated by CDC.

According to CDC and state health department officials, progress in collecting and using KABB data has been impaired in part by staffing problems. Some states tried at first to conduct KABB surveys in house but

later realized that they lacked the expertise to successfully complete the surveys. Staff diversions to other AIDS priorities, such as addressing state AIDS legislation, also contributed to delayed KABB data collection in some states. CPS hired two additional staff in October 1988 specifically to provide technical assistance to state and local health departments to help them develop program objectives linked to KABB data.

CPS officials reported that because of staff shortages, they have not been able to conduct other important program monitoring activities. For example, at the end of 1988, CDC had not evaluated state and local health department HIV prevention programs. This is an essential component of technical assistance, according to CDC program requirements. Staff shortages also precluded assistance in coordinating programs aimed at preventing HIV transmission among intravenous drug users.

Funding Cycles for HIV Prevention Programs

We reported in 1987 that the federal public health education response to the HIV epidemic appeared uncoordinated.[5] Experts we interviewed told us that the patchwork of federal and state funding and the lengthy and cumbersome grant application procedure had prevented quick response to the epidemic in many instances. For example, some public health officials were concerned that public health educators and other professionals were spending inordinate amounts of time responding to requests for proposals instead of providing HIV education.

Table 2 shows the funding cycles for HIV prevention programs. State and local health departments will have received HIV prevention funds on eight occasions in less than 3 years, or an average of every 4 months.

[5] AIDS Prevention: Views on the Administration's Budget Proposals (GAO/HRD-87-123BR, Aug. 12, 1987).

Table 2: Flow of AIDS Funds From CDC to State and Local Health Departments (Apr. 1986 to Jan. 1989)

Dollars in millions

Type of AIDS prevention funds	Date of award	Awards
Health education/risk reduction	Apr. 1986	$9.5
Health education/risk reduction	Aug./Sept. 1986	1.7
Counseling and testing	Aug. 1986	9.9
AIDS prevention[a]	Apr. 1987	24.4
AIDS prevention	Sept. 1987	26.6
AIDS prevention	Apr. 1988	86.3
AIDS prevention	Sept. 1988	8.9
AIDS prevention	Jan. 1989	129.7

[a]In fiscal year 1987, CDC consolidated the health education and risk reduction, and counseling and testing awards into one AIDS prevention award.

Both CDC and state officials told us that, while these funds were needed, the irregular flow of funds has made it difficult to plan and manage effective programs. For example, in 1987, health departments had developed annual program plans based on specific funding awarded in April. In September, they were awarded additional funding that had to be committed within the next 7 months. Also, the same staff are frequently responsible for both developing program applications and implementing programs, which are competing priorities. CPS staff are also diverted from their program implementation responsibilities to award new projects.

The reasons for this disruptive transfer of funds have largely been beyond CDC's control. In fiscal year 1988, for instance, the administration had CDC conduct a national seroprevalence study[6] and a nationwide mailing of an HIV information brochure. As a result, CDC reduced the prevention funds available to state and local health departments. Rather than reduce monthly expenditure levels to the health departments, however, CPS reduced the 1988 funding cycle from 12 to 8 months. Consequently, CPS awarded fiscal year 1989 funds in January 1989 rather than late April 1989.

In part, however, the irregular funding cycles also reflect CDC's response to rapidly changing knowledge about the HIV epidemic. CDC officials stated that disruption of the funding cycles was necessary to address important, unanticipated needs, such as activities targeted to minorities.

[6]A seroprevalence study measures the relative frequency or number of individuals in a given population or community whose blood tests positive for antibodies to an infection, in this case the number of Americans with HIV infection.

Future changes in the course of the epidemic may cause continuing discontinuities in funding cycles to meet new needs as quickly as possible.

Agency Comments

We discussed the contents of this report with responsible CDC program officials, who agreed with the information presented. The Director of CDC acknowledged that limited staff hampered the HIV program at the Center for Prevention Services, even though CDC allocated staff to the HIV program from other public health programs. He told us that additional staff could not be diverted to HIV from other core programs, including immunization and sexually transmitted disease control programs. The Director of CDC also emphasized that CPS staff have made significant positive contributions in the HIV prevention area, even though understaffing has resulted in very heavy workloads.

Unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies to the Secretary of Health and Human Services, the Director of CDC, and other interested parties and will provide copies to others on request. The major contributors to this report are listed in appendix I.

Sincerely yours,

Janet L. Shikles
Director of National and
Public Health Issues

Appendix I

Major Contributors to This Report

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United States General Accounting Office

GAO

Report to the Chairman, Committee on Governmental Affairs, U.S. Senate

May 1990

AIDS EDUCATION

Public School Programs Require More Student Information and Teacher Training

GAO/HRD-90-103

GAO
United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-238881

May 1, 1990

The Honorable John Glenn
Chairman, Committee on
Governmental Affairs
United States Senate

Dear Mr. Chairman:

This report responds to your request and subsequent discussions with your staff concerning certain programs to prevent the spread of the human immunodeficiency virus (HIV), which causes acquired immunodeficiency syndrome (AIDS).[1] The programs at issue are managed by the Centers for Disease Control (CDC), an agency in the Department of Health and Human Services. As part of our ongoing review of AIDS education and prevention efforts, you asked us to obtain information on CDC's AIDS education program aimed at school-aged youth.

We have surveyed the public school districts across the nation regarding their AIDS education efforts and met with CDC officials. Our report describes the reported growth of AIDS education programs and identifies areas needing improvement.

Unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies to the Secretary of Health and Human Services, the Director of CDC, and other interested parties and will provide copies to others on request. Please contact me at (202) 275-6195 if you or your staff have any questions concerning this report. Other major contributors are listed in appendix VI.

Sincerely yours,

Mark V. Nadel

Mark V. Nadel
Associate Director, National and
Public Health Issues

[1] Also at your request in September 1988, we addressed education efforts to reach high-risk persons in AIDS Education: Issues Affecting Counseling and Testing Programs (GAO/HRD-89-39, Feb. 3, 1989) and AIDS Education: Staffing and Funding Problems Impair Progress (GAO/HRD-89-124, July 28, 1989).

Executive Summary

Purpose

About 20 percent of people with acquired immunodeficiency syndrome (AIDS) are in their 20s. As the human immunodeficiency virus's (HIV) median incubation period is estimated at nearly 10 years, many of these people probably were infected with HIV while they were teenagers. AIDS cases among individuals in their 20s increased by 41 percent during 1989, similar to the overall increase in AIDS cases. Without a human vaccine or cure available, HIV education programs are critical as the primary weapon against the medical and social costs of this potentially catastrophic health threat. Centers for Disease Control (CDC) awards for school-based education began with $7 million in 1987 and expanded to $25 million in 1989. Limited information is available about the extent of this rapidly growing school-based program.

The Chairman of the Senate Committee on Governmental Affairs asked GAO to assess the progress of school HIV education programs for his ongoing review of education efforts led by CDC.

Background

Many teenagers are engaging in sexual behavior that can transmit HIV. Some youth also experiment with drugs that cloud their judgment, increase sexual activity, and cause addictive cravings—all of which can lead to high-risk behaviors.

HIV education programs provide information on what AIDS and HIV are, how the virus is spread, and what people can do to prevent infection. Behavioral skills components, such as how to say no to drugs, are also included to teach children how to modify behavior. Training for HIV teachers is critical. Not only must they impart correct information on HIV, they also must impel youth to avoid risky behavior. The latter requires skills in persuasion, group dynamics, and decision-making.

CDC, the lead federal agency for HIV prevention, initiated a nationwide education program late in 1986. It envisioned a multiyear effort to build the nation's school-based HIV education program aimed at reaching the 90 percent of children who are in U.S. public schools. As its main function, CDC provides funds and technical assistance to state and selected local education departments through cooperative agreements. Education departments then design and operate their own programs.

GAO surveyed by telephone officials from a nationwide sample of school districts and the 13 local districts whose direct CDC funding began in 1987. The purpose was to determine if HIV education was offered and

what teacher training was offered. GAO also reviewed CDC records relating to planning and monitoring data collected by the funded state and local education departments. GAO interviewed CDC officials and reviewed existing literature.

Results in Brief

CDC-led nationwide education efforts are not yet commensurate with the epidemic's potential for disaster. Two-thirds of the nation's public school districts reported providing formalized HIV education for students in the 1988-89 school year. It is not, however, offered at every grade level, especially the upper grades, where the probability of sexual activity is highest. Most CDC-funded education departments do not collect from students the essential planning and monitoring information needed to set program priorities and evaluate success. This is due to a lack of staff and difficulty in obtaining community support to collect sensitive sexual and drug use data. One of five HIV teachers received no training. Although the majority of HIV teachers did receive training, it was often insufficient—too brief and coverage of important topics was limited. CDC provides no guidance to districts on the appropriate length of such teacher training.

Principal Findings

HIV Education Usually Required, but Not at All Grade Levels

CDC believes it is crucial that students at every grade level receive age-appropriate HIV education to expand on and reinforce knowledge over the years. But only 5 percent of the school districts required that HIV education be provided at every grade level. The most coverage is in the middle grades (7 through 10) and the least in the upper grades, where the probability of sexual activity is highest.

School district officials told GAO they were restricted by already crowded curricula (see ch. 2). Most public school districts (66 percent) required that HIV education be provided at some point in grades 7-12 during the 1988-89 school year. Of the districts that did not require HIV education, most enrolled fewer than 450 students. CDC officials should pay particular attention to the needs of these smaller districts for HIV education.

Important Planning and Monitoring Data Are Inadequate

The data collected by state and local education departments on students' knowledge, beliefs, and behaviors are inadequate. This hampers efforts to set program priorities, evaluate success, and improve operations, judging by our review of CDC records and discussions with CDC officials. Without such information, educators and CDC attempting to assess high-risk behaviors of youth must rely on the results of other surveys, which may not be related to specific student populations. In 1988, CDC provided funds through cooperative agreements, of which one key objective was to gather adequate student data. CDC has developed suggested questions for districts to ask students (see app. III).

But most recipients did not collect this essential information, CDC officials said, for various reasons. Because this was the first program year for many states, some lacked staff to carry out the requirement. In other cases, recipients could not obtain state or local authorization to ask questions about students' behavior, particularly sexual or drug use behavior (see ch. 2).

Training for Some HIV Teachers Absent or Insufficient

Although education authorities recommend that teachers receive at least 12 hours of training, one-fifth of HIV teachers received no specialized training in the subject. Most HIV teachers (83 percent) did receive training, but it was less than recommended. Of the nation's districts that offered HIV education, teachers in 67 percent received training of 10 hours or less, with a median of only 7 hours. Additionally, in many districts limited training time was devoted to key topics, such as the importance of using condoms.

Most officials of school districts nationwide that offered HIV education expressed a desire to provide more training to their current HIV teachers. Officials stated that the minimal training currently being obtained was related to such problems as not enough in-service days to offer extensive HIV training and teachers being reluctant to attend training outside of regular work hours. One local official, citing limited resources, said the district had a choice of reaching all its HIV teachers with a little training or only a few with more in-depth training.

In contrast, the 13 school districts directly funded by CDC generally trained a higher percentage of teachers, had longer training sessions, and covered key topics more extensively than other districts nationwide. CDC and state officials attributed this difference to the direct CDC funding and the higher incidence of AIDS in these districts (see ch. 3).

CDC's HIV education guidelines recommending that HIV teachers be trained were issued in January 1988. But the agency has not yet set standards for the number of training hours required to effectively teach about HIV or the amount of time to be spent on important topics. While CDC did not disagree that 12 hours may be the minimum necessary, agency officials said they are in the process of researching the extent of training necessary.

Recommendations to the Secretary of Health and Human Services

GAO recommends that the Secretary require the Director of CDC to (1) take a leadership role in developing approaches to extend and reinforce HIV-related education for 11th- and 12th-grade students, (2) work with state education agencies to assist smaller school districts in overcoming resource or community barriers that prevent them from offering HIV education, (3) ensure that state and local grantees collect adequate data from students to evaluate and improve school-based programs, and (4) develop guidelines for the training of HIV educators.

Agency Comments

GAO discussed the contents of this report with the CDC Deputy Director (HIV), the Deputy Director of CDC's Center for Chronic Disease Prevention and Health Promotion, and the Director of the Division of Adolescent and School Health. They generally agreed with the information presented. The officials stated that HIV education should be locally determined and consistent with parental values. They believe that HIV education has expanded to other school districts since GAO collected its data (summer 1989). CDC officials stated that data on students' knowledge, beliefs, and behaviors needed improvement. They also said that some of the data available, even if not generalizable, could be useful if employed in an appropriate manner. After only 1 or 2 years of funding, most school districts in the nation have rapidly begun to provide some form of HIV education, although much remains to be accomplished, the officials said (see ch. 4).

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Abbreviations

AIDS	acquired immunodeficiency syndrome
CDC	Centers for Disease Control
GAO	General Accounting Office
HIV	human immunodeficiency virus
IV	intravenous
KBB	knowledge, beliefs, and behaviors
STD	sexually transmitted disease

Chapter 1

Introduction

American youth are not immune to the potentially catastrophic health and social costs of acquired immunodeficiency syndrome (AIDS). About 20 percent of people with AIDS are in their 20s. Former Surgeon General Koop told the House Select Committee on Children, Youth, and Families in 1987 that "Since the time between infection with the AIDS virus and onset of symptoms may be several years, some proportion of those aged 20-29 who have been diagnosed with AIDS were most likely infected as teenagers." Today, the median incubation period for the human immunodeficiency virus (HIV) is estimated at nearly 10 years. Of additional concern, the number of AIDS cases in the 20- to 29-year-old age group increased by 41 percent from January through December 1989, which was similar to the overall increase in AIDS cases.

Scientific progress has created "a dangerous, perhaps even growing, complacency toward an epidemic many people want to believe is over," the chair of the National Commission on AIDS warned in 1989. But with no human vaccine or cure yet available, AIDS prevention programs are the primary weapon against the medical and social costs of this epidemic. Centers for Disease Control (CDC) awards for youth education were initiated in 1987 at $7 million and grew to $25 million by 1989. Specific information about HIV programs targeted to youth in schools has been limited.

The Chairman of the Senate Committee on Governmental Affairs asked us to assess the status of school AIDS education programs as part of his ongoing review of education and prevention efforts led by CDC.

Background

AIDS is the final stage of the disease caused by infection with HIV. Health experts now realize that HIV infection occurs years before AIDS is manifest; during this time the virus is infectious to other people. Therefore, current emphasis is on education about the dangers of HIV transmission. In the remainder of this report, we refer to education related to all phases of the disease as HIV education.

Youth are at risk of HIV infection through sexual and drug use behavior. They may be at even higher risk of heterosexual transmission than the general population. One study found that many youth lack information about how HIV is transmitted and how to avoid it. Yet even those youth who did have information did not change their behavior.

The HIV Epidemic and Youth

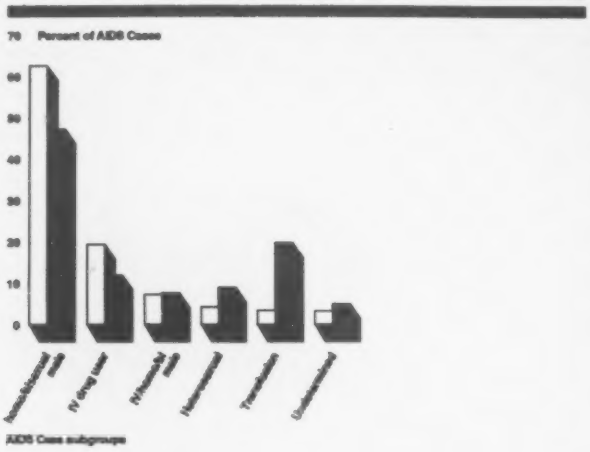
The next generation of persons with AIDS is becoming infected now, as the Journal of the American Medical Association noted in August 1988. There are currently over 35 million youth aged 10-19 in the United States; this number should increase by 10 percent in the 1990s, with half of the increase coming in minority groups, who are at higher risk. "The potential for this epidemic to spread like wildfire among teenagers is blatantly obvious," the chairman of a task force on adolescents for the American Academy of Pediatrics states.

Several New York state and city studies found that 10 in 1,000 19-year-olds and 1 in 1,000 15-year-olds giving birth statewide were infected with HIV. The first large study to determine the rate of HIV infection on college campuses found that about 2 in 1,000 students were infected.[1]

AIDS-infected youth age 12 and over are less likely to have contracted the disease through homosexual behavior or IV drug use than are AIDS-infected individuals generally, data from the Children's Defense Fund show (see fig. 1.1). But transmission of the virus through heterosexual contact is twice as prevalent among youth. The data are drawn from 73,262 total AIDS cases reported through September 1988 (individuals age 12 and over), of whom 865 were youth.

[1] President of the American College Health Association.

Figure 1.1: Distribution of AIDS Cases Among Adults Versus Adolescents by Means of Transmission (Through Sept. 1988)



Source: Children's Defense Fund, Teens and AIDS: Opportunities for Prevention, November 1988; Adolescent Pregnancy Prevention Clearinghouse.

Youthful Sexual Behaviors Increase Risk of HIV

Former Surgeon General Koop has said, "Everything that turns up confirms heterosexual spread [of AIDS], numerically and geographically." Further, heterosexual transmission among inner-city minority youth is a clear and present danger, said Karen Hein of the Albert Einstein College of Medicine, who cites an analysis of the most recent data from New York City. Yet the myth that there is no need to educate heterosexuals because the disease is not spreading beyond homosexual or drug-using people persists, the Citizen's Commission on AIDS says. This belief hinders adequate education efforts.

Many teenagers engage in sexual behaviors, such as unprotected intercourse or intercourse with two or more partners, that can transmit HIV. Data show that:

1. Youth have sex at an early age—the average age of first intercourse is 16. The Office of Technology Assessment reports that 78 percent of males and 63 percent of females have sex while teenagers.

2. For many adolescents, sexual activity is frequent or often with more than one partner. Among unmarried females 15 to 19 years old, about 40 percent reported having sex once a week or more, and 51 percent reported having two or more partners. An official of a national organization serving youth said that adolescents interpret a "long-term monogamous relationship" to be one with their current lover that lasts for several months.

3. Much of teenagers' sexual intercourse occurs without the protection of condoms. Although estimates vary, studies we reviewed found that only about one-quarter of sexually active adolescents used condoms. Serial monogamy in combination with the reluctance to use condoms with one's "monogamous" lover exposes youth to the risks associated with unprotected intercourse with multiple partners.

Homosexual youth, particularly males, are of special concern as they have been one of the high-risk groups for HIV transmission in the United States. As youth, these teens also search for their identity and struggle to establish satisfying relationships, leading them, in some cases, to experiment with heterosexual affiliations. This places lesbian youth, who generally would be in a low-risk category, at heightened risk of infection. Such exploration also serves as a possible link between homosexual and heterosexual youth in the transmission of HIV.

Thus, many teenagers are at risk of HIV infection through sexual contact. The gravity of the situation is indicated by the fact that young people have the highest incidence of sexually transmitted disease (STD) in comparison with other age categories. Nearly one-half of the 20 million STD patients are under age 25. About 2.5 million teenagers contract a sexually transmitted disease annually. The incidence of STD among minority youth is generally far higher than among their white counterparts.

Women who become pregnant through unprotected sexual activities place not only themselves, but also their unborn children, at risk of HIV infection, as the virus can be transmitted perinatally. Ten percent of teenage women become pregnant every year, and 40 percent of U.S. teens will become pregnant at least once before age 20, the Guttmacher Institute reports. There are 1 million teen pregnancies each year.

Drug Use Also Places Youth at Risk of HIV

Some teenagers are directly at risk of contracting HIV through the sharing of contaminated needles used to inject intravenous (IV) drugs. In 1986, 1 percent of high school seniors reported using heroin and 17 percent reported using cocaine, which also can be intravenously injected, a National Institute on Drug Abuse report asserts. In addition, about 3 to 4 percent of the 15- to 16-year-olds in California, Michigan, and the District of Columbia had reported using intravenous drugs, a December 1988 CDC study says.

In addition, drugs with which some adolescents experiment increase their risk of HIV infection by clouding their judgment, increasing their sexual activity, or causing addictive cravings. All can lead to high-risk sexual behaviors. Some then become involved with other drug users who have contracted HIV. For example, young women who use cocaine or crack may engage in relationships with men who use heroin, an injectable drug. Such youth also may exchange sex for money to finance their substance abuse.

Youth Lack Knowledge, Not Changing Behavior

The National Adolescent Student Health Survey, conducted in 1987 with 8th and 10th graders, indicated a serious lack of knowledge on AIDS topics, such as mode of transmission and means of prevention. In particular, youth had some knowledge about how HIV was transmitted, but did not alter their behavior accordingly. Some changed their behavior groundlessly, for example, not touching doorknobs or sharing popcorn.

In a 1986 study of teens in Massachusetts, 96 percent said they knew about AIDS, but only 15 percent had changed their sexual behavior because of concern about it. Of these, only 20 percent took steps such as using condoms or abstaining from sex; 54 percent said they did not worry at all about catching AIDS.

Teens experiment freely with drugs and sex for the same reason that they drink or smoke too much and drive too fast. They tend not to believe in their own mortality, states the North American Directory of Programs for Runaways, Homeless Youth and Missing Children. Reaching teens with the AIDS message is difficult because most youth do not even think in terms of tomorrow, let alone 5 or 10 years down the road, the latency period for AIDS.

Adolescence is characterized by impulsiveness, a desire for immediate gratification, and a tendency to question authority. The latter is especially true when advice from authorities disagrees with the adolescent's

own limited personal experiences. Other adolescent characteristics, such as their search for an identity and self-esteem with a subsequent need for peer approval, make it difficult for them to resist peer pressure. A lack of social experience, coupled with the dynamics of new sexual relationships, makes it hard for adolescents to justify abstinence from sex or drugs, or the use of condoms.

Objectives, Scope, and Methodology

We focused this review on determining the status of the following:

- Student HIV education required by school districts' formal curricula for grades 7-12, what grade, course, and for how many class periods it is taught.
- Data collection by CDC-funded state and local education departments on students' HIV knowledge, beliefs, and behaviors for use in planning, monitoring, and improving courses.
- In-service training for HIV classroom teachers and for how long topics are covered.

We conducted structured telephone interviews of superintendents or their designated staff from 232 randomly selected school districts and the 13 local districts directly funded by CDC in 1987.[2] Our findings for the randomly selected districts are representative of the approximately 14,200 school districts nationwide in our universe.[3] The findings represent the status of required student HIV education and HIV teacher training for all school districts in our universe in the 1988-89 school year. The margin of error for our findings is generally ± 5 to ± 10 percentage points, depending on the item. Sampling errors for specific numbers are provided in appendix II. Our findings for the 13 CDC directly funded districts reflect the status of HIV education in these cities, which were funded because they had high AIDS caseloads.

Because the school district generally has considerable control over local HIV education, we discuss the reported activities and requirements of

[2]We completed interviews in 93 percent of the 232 randomly selected districts and all the 13 other districts. Although we did not sample on the basis of student population, we estimate that the responding districts accounted for 96 percent of public school students in our universe.

[3]We used the 1987-88 public education agency universe of the Department of Education's common core of data. This is derived from a survey that includes the approximately 15,600 school districts in the nation in 1987-88. The universe for our survey excluded local school districts where the highest grade was less than 7, nonlocal school districts (such as supervisory/regional districts and state-operated agencies), and 49 superintendent offices in California that were designated as local districts but had no student counts. This left about 14,200 school districts from which we sampled.

school districts. Our estimates of the extent of HIV education are stated in terms of the frequency with which school districts reported various HIV education activities. They do not include estimates of the number of students receiving HIV education. Student estimates would have required data collection at the school level, which was beyond the scope of our study.

Our information on student HIV education reflects what school district officials reported was required by school districts' formal curricula. We did not talk to teachers or visit classrooms to see if HIV teachers were actually adhering to school districts' curricula requirements, although we did visit one location before our survey. Nor did we collect information about HIV education occurring informally or as part of elective courses. In addition to reviewing the literature related to AIDS education, we drew on two studies to help assess what students were taught in the classroom. (See p. 23.)

The information we present on in-service teacher training relates only to the training that school districts reported was received by classroom teachers who teach about HIV. Also, this information relates only to districts that required HIV education.

We conducted our work at CDC headquarters in Atlanta between May and December 1989. Telephone interviews were done between May 31 and August 18, 1989. Additionally, we interviewed CDC officials responsible for managing these HIV activities and reviewed associated financial records, cooperative agreement documents, and other CDC records. We discussed the results of our school district interviews with officials from CDC, six states that had the most districts providing HIV education in our sample, and three local education departments on the east and west coasts to obtain their reactions. Their comments were incorporated where appropriate.

Our work was done in accordance with generally accepted government auditing standards. At the request of the Committee, we obtained oral rather than written agency comments on a draft of this report.

Chapter 2

Student HIV Education

Nationwide, the majority of school districts had incorporated some form of HIV education into their curriculum in the 1988-89 school year. While nearly all large schools offered such training, a disturbing number of smaller school districts (fewer than 450 students) had not required HIV education for their students. Even schools that offered HIV education programs typically did not require them at all grade levels. Only 5 percent of school districts nationwide offered HIV education at each grade level in the 1988-89 school year. HIV education often was not provided at the highest grades, where the probability of high-risk behaviors by youth increases.

The Centers for Disease Control has recommended that HIV education be provided at each grade level. CDC believes schools should present age-appropriate HIV information that is expanded upon and reinforced as the students pass from one grade to another.

CDC's School-Based HIV Education Program

CDC is the lead federal agency for HIV prevention programs. Its Division of Adolescent and School Health, in the Center for Chronic Disease Prevention and Health Promotion, has responsibility for youth education. CDC's national education program primarily targets students enrolled in public schools because these schools can reach about 90 percent of the young people in kindergarten through 12th grade. CDC describes this as a multiyear effort to build the nation's school-based HIV education program. CDC encourages state and local education departments to

- develop curricula and necessary support materials (such as texts, videos, and workbooks);
- train HIV education teachers;
- educate parents to support HIV education; and
- monitor the programs by collecting student information.

CDC Funding Since 1987

Since it began efforts toward HIV education in schools in late 1986, CDC has funded programs principally through cooperative agreements with state and local education departments. In September 1987, CDC awarded $5.4 million to 14 state and 13 local education departments, including the District of Columbia. These 27 awards, ranging from $119,500 to $342,607, involved education departments that served areas with a high incidence of AIDS cases.

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Also in 1987, CDC awarded $1.8 million to 15 national organizations, such as the Council of Chief State School Officers and the National Association of State Boards of Education. These organizations were to use the funds, ranging from $92,919 to $302,000, to help increase the number of schools and other organizations providing HIV education to youth.

In August and September 1988, CDC extended funding to a total of 53 state and territorial and 17 local education departments. These 70 agreements totaled $16.7 million, ranging from $81,182 to $441,267. Similarly, CDC awarded $3.8 million to 19 national organizations in 1988. In 1989, CDC awarded a total of $25 million to all these organizations.

Generally, state and local education departments are responsible for managing their cooperative agreements. CDC provides general guidance and oversight (see app. I for CDC's guidelines). This cooperative effort stresses the importance of providing immediate education about high-risk behaviors to students. Specific education department activities include developing curricula and materials, training teachers, educating parents, and completing surveys of students' HIV knowledge, beliefs, and behaviors.

State Involvement in HIV Education

States have been addressing HIV education issues, as shown by a December 1988 survey conducted by the Council of Chief State School Officers. The council canvassed all 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, and American Samoa. For these 54 jurisdictions, the council reported: (1) 41 had either a state law or state policy concerning HIV education in schools; (2) 41 had a curriculum or a curriculum guide for HIV education, of which 32 were advisory and 9 mandatory; and (3) 41 provided teacher in-service training programs for HIV education. Only two states said they had not addressed any of the above three categories.

That HIV education was required in 28 states and the District of Columbia was reported in another survey covering 55 states and territories. It was conducted by the National Association of State Boards of Education in May 1989.

Most Districts Required HIV Education in 1988-89 School Year

Sixty-six percent of school districts nationwide reported to us that they required students to receive HIV education as part of their formal curricula in the 1988-89 school year. Of the remaining districts, 27 percent did not require HIV education, and 7 percent could not be contacted or refused to participate in our survey. Most districts that did not require HIV education had fewer than 450 students; very few had 2,500 or more students. CDC should pay particular attention to these smaller districts to determine their needs in initiating HIV education. The 13 directly CDC-funded school districts all required students to receive HIV education, as their cooperative agreement funding was earmarked to help provide such education.

Reasons why school districts required HIV education include the following:

- State mandates requiring local districts to teach HIV education and districts' initiatives to respond to the HIV epidemic.
- The national HIV education program and media attention about HIV.

As to why some districts did not require HIV education, the following reasons were offered:

- Conservative community values, fear of community reaction, or low incidence of HIV infection locally.
- Insufficient school time to give students the necessary hours of instruction as well as parental reluctance for schools to teach about "safe sex."

Some districts not requiring HIV education indicated that they planned to implement such programs soon or were in the process of developing HIV teaching guides. Also, some districts provided informal HIV education either during a school assembly or at the initiative of individual teachers, they said.

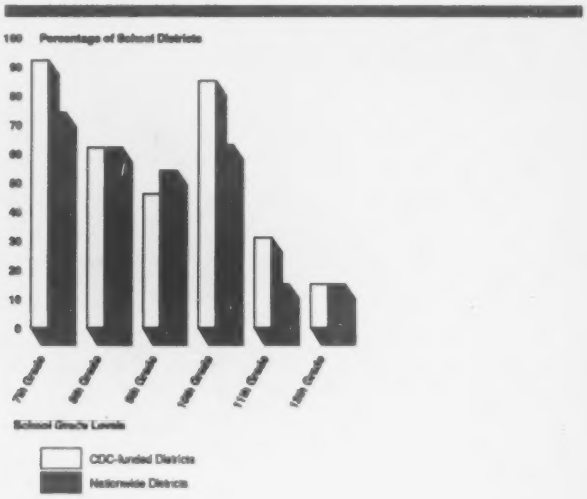
HIV Education Not Provided at All Grade Levels

Very few school districts required HIV education in each grade, our survey of districts with grades 7-12 showed. Only 5 percent of districts with grade levels 7 through 12 nationwide, and 1 of the 13 high caseload districts directly funded by CDC, required such education at each level. It is crucial that sufficient classroom time be provided at each grade level, CDC guidelines advise. This helps assure that students acquire essential age-appropriate knowledge about HIV and have the information expanded and reinforced each year. CDC and almost all state officials

said already crowded curricula prevented districts from requiring HIV education at all grade levels.

Most school districts nationwide and the CDC-funded districts required that students receive HIV education at some time in the 7th through 10th grades. About three-quarters of districts nationwide required students to receive HIV education in the 7th grade, while few offer it at upper grade levels (see fig. 2.1).

Figure 2.1: Grade Levels at Which HIV Education Usually Is Taught (1988-89)



Note: Percentages total to more than 100 because school districts may require HIV education in more than one grade.

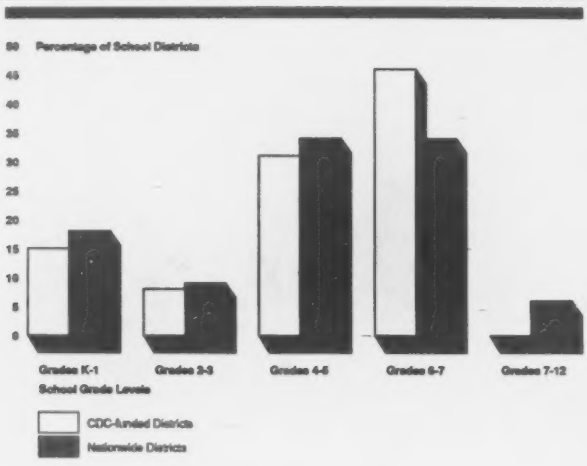
Most districts nationwide (79 percent) and most of the directly funded districts (69 percent) required HIV education in health classes, as recommended by CDC. Health usually is taught in grades 7 through 10, CDC officials say. Our data show a drop in HIV education in grades 11 and 12.

Even if health is not offered in these grades, HIV education should be continued in some format for older teens, in accordance with CDC recommendations. The increasing likelihood of the onset of sexual activity and the need for reinforcement of the AIDS message offer compelling arguments for doing so.

HIV Education Introduced in Primary Grades

Most districts reported that they had begun HIV education in formal curricula before the seventh grade—over half of the nationwide and CDC-funded districts that required HIV education had introduced it by the fifth grade (see fig. 2.2). CDC officials recommend that age-appropriate HIV education be provided at each grade level. If this recommendation were strictly followed, then HIV education should be available in first grade or kindergarten. However, given the early introduction of training, most students received HIV information before the average onset of sexual or IV drug use behavior.

Figure 2.2: Grade Levels HIV Education First Introduced Into Formal Curricula (1988-89)

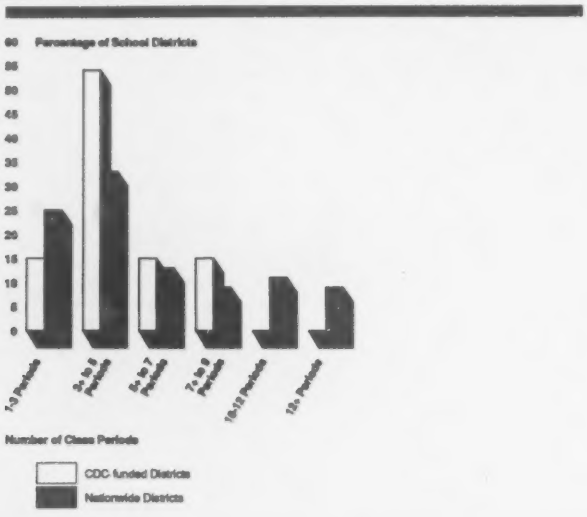


Note: Sampling errors for these percentages are 7 percentage points or less.

Time Devoted to HIV Education Varied

Nationally, from 1 to 40 class periods were required by HIV curricula during the academic year, the school districts reported. A class period usually lasts about 50 minutes. Nationwide districts and the 13 CDC-funded districts required students to receive a median of five class periods of HIV education. Twenty percent of districts nationwide reported that 10 or more class periods were required, and 25 percent reported that 3 periods or fewer were required (see fig. 2.3).

Figure 2.3: Number of Class Periods of HIV Education (1988-89)



Planning and Monitoring Data Inadequate

By the end of the 1988-89 school year, most of the 70 state or local education agencies receiving CDC grants had not collected essential planning and monitoring data. Of the 70 grantees, 14 did not even conduct the necessary surveys on students' HIV knowledge, beliefs, and behaviors (KBB), and 3 departments had not provided necessary data to CDC to evaluate sampling results. Forty-five conducted surveys that did not meet essential standards—they were not generalizable and/or did not contain questions relating to students' behaviors. Only eight collected adequate data. Of the 56 departments that did surveys, 27 obtained sex and drug behavior information, but only 8 obtained results that met both essential standards. The 70 HIV education cooperative agreements with state and local education departments that CDC funded in 1988 included a provision to gather this planning and monitoring information.

KBB data are critical to managing, evaluating, and improving state and local education department HIV education programs. Using baseline KBB

survey data, an education department can identify students' knowledge about HIV and the extent to which behaviors that spread HIV are practiced. This information then can be used to establish educational priorities and set objectives for changing attitudes and reducing risky behaviors. Follow-up KBB surveys can provide a basis for measuring program impact and evaluating results. Without such information, CDC and educators must rely on proxy information on the general trends of sexual and drug behavior reported by other surveyors, which may not be related to their specific population of youth.

CDC identified two essential standards for effective KBB surveys:

1. Results should be generalizable to the student population. Such results provide an accurate picture of the population and can be used to make decisions about the entire HIV program. On various occasions, such as CDC's November 1988 School Health Education Workshop, CDC noted the importance of obtaining such statistically useful survey information.

2. Questions about students' sex and drug behavior should be included to provide essential information on the extent to which students engage in risky behaviors that spread HIV. Because the basic purpose of HIV education is to eliminate such behavior, CDC views collection of information about students' sex and drug practices as essential to setting program priorities and monitoring results. CDC has developed a questionnaire that school districts can use to assess students' KBBs (see app. III).

In our opinion, the KBB data collected are insufficient because the data are often not generalizable and because of the limited extent of behavioral information. CDC officials stated that KBB data needed improvement, but that some of the data could be useful, although they did not meet essential standards. They stated that some education agencies (1) lacked available staff to collect them because this was the first program year for many states and/or (2) had difficulty obtaining authorization to gather certain sensitive information regarding students' sexual or IV drug behavior. Among the obstacles to obtaining such data was the perceived community concerns about gathering data on students' sexual or IV drug behavior.

Much more remains to be learned about how to motivate long-term changes in the sexual and drug-using behaviors that spread HIV, as we

testified in June 1988.[1] Neither public organizations nor private foundations providing HIV education have done much to ascertain the effects of their programs, recent research shows. Faced with methodological difficulties, limited resources, and the urgency of controlling the epidemic, early education programs skimped on evaluation. As a result, information about the effectiveness of public and private programs has accumulated slowly. But tight budgets and the urgency of slowing the spread of HIV among youth only heighten the importance of understanding the effectiveness of education programs.

The federal government should take the lead, we testified, in conducting rudimentary studies of what does and does not work in HIV education. Although school health education is an old field, there has been little research on how to modify it for HIV education. The particular challenge is not solely to impart information about the epidemic to youth but to modify behaviors that place them at risk.

In 1988, CDC contracted with IOX Assessment Associates to conduct a $3.2 million, 5-year study of what educational approaches work best with youth in modifying their high-risk behaviors. While awaiting its completion, valuable KBB data should be collected and used to plan and modify programs.

Some Sensitive Topics and Behavior Change Skills Not Addressed

Two other studies provide some insights on what students have been taught about HIV:

1. More than 90 percent of public school sex education teachers surveyed by the Alan Guttmacher Institute[2] reported that they covered selected HIV-related topics. For example, 96 percent reported explaining

[1] Issues Concerning CDC's AIDS Education Programs (GAO/T-HRD-88-18, June 8, 1988).

[2] J. D. Forrest and J. Silverman. "What Public School Teachers Teach About Preventing Pregnancy, AIDS and Sexually Transmitted Diseases," Family Planning Perspectives, Vol. 21, No. 2, Mar./Apr. 1989.

how HIV is transmitted (see table 2.1). However, some of the more sensitive topics, such as homosexuality or "safer sex" practices, were covered less frequently. The nationwide survey covered public school sex education teachers in grades 7-12.[3]

Table 2.1: HIV-Related Topics Covered by Sex Education Teachers Nationally

Numbers in percent

HIV-related topics covered	Covered by teachers
How AIDS is transmitted	96
Effects of the disease	94
Symptoms of the disease	91
Condoms as prevention	91
Sexual decision-making	90
Abstinence from intercourse	89
Importance of notifying partners if infected	86
Sexual monogamy as prevention	85
Confidentiality of medical treatment	77
Homosexuality	69
Specific sources of help for students	65
"Safer sex" practices	64

Many teachers responding provided information about the condom and how to use it, according to the survey, as table 2.2 indicates.

Table 2.2: Condom-Related Topics Covered by Sex Education Teachers Nationally

Numbers in percent

Condom-related topics covered	Covered by teacher
How to use a condom	77
Teach that condoms should be put on before any vaginal contact by the penis	68
Encourage condom use for prevention of HIV and other sexually transmitted diseases	53
Address such concerns as reduced sexual pleasure and lack of spontaneity	46
Teach that condoms should always be used with spermicides	45

[3]Of the 9,800 teachers surveyed, 4,241 responded, yielding a response rate of about 45 percent. The response rate differed by teacher specialty. It was highest among nurses. Respondents were similar to nonrespondents in metropolitan status, although teachers from schools with 501-1,000 students were slightly more likely than those from schools with larger or smaller enrollments to respond to the survey. Teachers from the North Central region of the country had a slightly higher response rate, and those from the South had a slightly lower response rate than those from other regions. The authors note that the size of the school and region of the country were not significantly related to the responses on a number of variables investigated, suggesting little bias by these factors, other than that by differences by specialty.

2. Some important prevention topics, such as proper use of condoms and peer resistance skills, were not included in many of the 43 secondary school HIV teaching guides reviewed by CDC in an unpublished study (see table 2.3), although CDC feels that the data should be further analyzed. The guides were obtained from CDC's AIDS School Health Education data base. CDC officials noted that the federal HIV education role does not mandate a specific school curriculum.

Table 2.3: Prevention Topics Included in Teaching Guides

Numbers in percent

HIV prevention topic	Covered by teaching guides
Personal responsibility	
Peer resistance and refusal skills	37
Enhancement of self-esteem	44
Modify own behavior	79
Abstinence	
Sex	93
IV drugs	91
Monogamy	
Mutually faithful with uninfected partner	47
Condoms	
Mentioned	93
Reduce risk of exposure to HIV	79
Additional protection if used together with spermicide	42
Used properly from start to finish with each sexual act	37
Instruction or demo on use	16
Drugs	
Avoid IV use	91
Do not share needles or syringes	91
Cleaning of works	12
Seek treatment if addicted	23

Chapter 3

Teacher HIV Training Often Inadequate or Lacking

About one-out-of-five HIV teachers in school districts we surveyed had not been trained in the subject. Even though most HIV teachers were [illegible] HIV training and the coverage of important [illegible]. Most of the officials of the districts [illegible] providing HIV teachers with addi-

Teacher training is a critical component of effective school-based HIV education. In June 1988, the Presidential Commission on the HIV Epidemic recommended that HIV teachers receive extensive in-service training before they begin instruction. In addition, CDC recommended in January 1988 that HIV teachers should receive specific training as soon as possible (see app. I).[1]

One-Fifth of Teachers Not Trained

Our survey showed that about one out of every five HIV teachers nationwide had not been trained by the end of the 1988-89 school year. Twelve percent of the school districts nationwide that required student HIV education provided no teacher training. In about two-fifths of the districts [illegible] training, officials said teachers do not need HIV training, [illegible] cited various barriers to training. These [illegible] training days and lack of money to pay for [illegible] teachers for training.

[illegible] available and utilized by the majority [illegible] specifically, 83 percent of HIV [illegible] actually received the training. [illegible] provided HIV teacher training, 91 percent [illegible] districts received HIV training.

[illegible] reported teacher training coverage were given [illegible] officials. Two state officials said that school districts understand that teachers need to receive HIV training. State mandates, HIV teachers requesting training, and CDC's emphasis on training were listed by other state officials as additional reasons. The extensive publicity concerning HIV and the ready availability of HIV teaching materials helped boost the number of teachers trained, CDC officials added.

[1]CDC, Guidelines for Effective School Health Education to Prevent the Spread of AIDS, Jan. 1988.

[2]Some schools require in-service training to be offered to teachers during duty hours or compensate teachers for the time necessary to complete such training.

Length of HIV Teacher Training Often Insufficient

While HIV teachers in school districts that required HIV education do receive HIV education training, it generally is not as extensive as education experts recommend or school districts want. Officials of state and local education departments and national education organizations believe that teachers should receive a minimum of 12 hours of HIV instruction. This provides basic information about HIV, they contend, and helps ensure comfort in discussing topics of human sexuality. More training time is necessary for teachers who lack a background in health education.

Generally, HIV teachers received less than 12 hours of training, school district officials nationwide told us (see table 3.1). In 67 percent of school districts nationally, HIV teachers received training of 10 hours or less; in 32 percent of districts, 4 hours or less.

HIV classroom teachers in the 13 CDC-funded districts generally received more in-service training than those nationwide—a median of 12 versus 7 hours. However, HIV teachers in almost one-half of the CDC-funded districts received training that lasted 10 hours or less.

Table 3.1: CDC-Funded School Districts Provide Lengthier Teacher Training Than Nationwide

	Hours of training		
Type of school district	Lowest quarter	Median	Highest quarter
13 CDC-funded districts	8	12	16
Other school districts nationwide	4	7	12

CDC has performed no systematic classroom observations to determine the nature of HIV education provided nationally. We visited one location before our survey and observed a range of teacher quality in terms of the information presented, teaching style, and student reactions.

CDC issued guidelines in January 1988 recommending that HIV teachers be trained as soon as possible. But it has not yet developed official or even preliminary standards for the number of training hours required by teachers to effectively instruct an HIV course. While CDC officials did not disagree with the 12-hour minimum, they contend that sufficient evidence on the optimal number of hours for HIV teacher training is not available to support a specific level of training. CDC is concerned that recommending a minimum amount of time for teacher training may be undesirable, as it may mistakenly be used as a standard. However, in light of the seriousness of the HIV epidemic, preliminary guidelines that

[illegible] as additional research data are available would be appropriate. For instance, guidance on the amount of time to be spent on individual topics to provide meaningful instruction would be useful to [illegible] a total time for the entire HIV teacher training [illegible]. Such guidelines on content and coverage would [illegible] in ensuring the quality of the HIV training.

Limited resources, such as funds for substitute teachers while HIV teachers are in training, prevented districts from providing more training, state and local officials said. Among their responses:

- The choice was between reaching all HIV teachers with a little training or only a few with more in-depth training.
- School administrators may not understand that training teachers to deal with sensitive HIV subjects requires more training time.
- Teachers in the 13 CDC-funded districts generally received longer training, because of the direct CDC funding available and/or because the higher incidence of HIV in their communities served as an impetus.

With respect to the latter, if a higher AIDS caseload has been an impetus for these districts, other districts should not wait for a similar problem to provide their motivation for pursuing HIV education. The chief benefit of HIV education is to prevent infection from occurring.

Limited Time Devoted to Important HIV Topics

[illegible] in some key topics in teachers' HIV training, [illegible] the insufficient length of in-service training. For [illegible] school districts, training covered 5 of 14 key [illegible] which educators contend is an insufficient [illegible]. These topics tended to cover sensitive subjects, such as the importance of using condoms and the dangers of unprotected homosexual intercourse and multiple sex partners. (See app. V for a list of the key topics with their coverage.)

Conversely, in the 13 CDC-funded districts, the 14 key teacher training topics almost always are discussed for more than 15 minutes, officials reported. Most of the districts addressed sensitive topics for more than 15 minutes. Topics included the importance of using condoms and the risks of unprotected homosexual intercourse. (See app. IV for a list of the key topics with their coverage.)

Teacher training should cover topics and approaches having the greatest potential for changing student behavior that could lead not only to

AIDS, but also to teen pregnancies and drug abuse problems, CDC guidelines say. Among these are modes of HIV transmission and behaviors that spread HIV; ways to discuss sensitive topics, such as the use of condoms and homosexual behavior; and ways to help youth resist persuasion, gain decision-making skills, and build self-esteem so they can resist risky behaviors. These topics should be covered for a sufficient amount of time—more than 15 minutes—to allow teachers to gain expertise, educators feel.

But teacher training for some controversial or sensitive HIV topics was limited, state and local officials noted, because school staff or individuals in the community were uncomfortable. With limited training time available to start with, one state official said, topics that are too sensitive for teachers or the community are just not substantively addressed.

Most Districts Would Like Additional HIV Teacher Training

More in-service training is needed, school district officials in 54 percent of districts asserted, and 25 percent said more HIV teachers are needed. School district officials nationwide listed several problems that inhibit their ability to give teachers additional training or train more teachers. Among these problems are the following:

- Too few in-service days available to do extensive training.
- Teachers' reluctance to attend training held outside of regular contract or working hours.
- Not enough money to pay for substitute teachers.
- Too few substitute teachers to release HIV classroom teachers for training.

In 12 of the 13 CDC-funded districts, officials want to provide more HIV training to teachers. In 7 of the 13 districts, officials said the number of teachers trained is fewer than needed. Officials listed barriers similar to districts nationwide, such as too few in-service days for extensive training, too little money to pay for substitute teachers, and too few substitute teachers to release HIV classroom teachers for training.

Conclusions, Recommendations, and Agency Comments

Conclusions

Two-thirds of the nation's public school districts reported HIV education programs in progress in grades 7-12 for the 1988-89 school year. Those not offering HIV education tended to be the smallest school districts. Additional focus on these districts is needed to ascertain their needs in initiating HIV education. But only 5 percent of school districts nationwide required HIV education at every grade level, as CDC recommends. HIV education drops off noticeably in the 11th and 12th grades, yet this is when students become more sexually active. Moreover, important data on students' knowledge, beliefs, and behaviors needed to plan and monitor HIV programs either have not been collected or are inadequate to set educational priorities, evaluate success, and improve HIV programs.

The majority of teachers in school districts nationwide that required HIV education have received in-service training on how to teach about AIDS. Such training, however, is not as extensive as the districts prefer or authorities recommend. One out of every five HIV instructors has received no training.

Judging by available statistics, youth are at risk of HIV infection through various sexual and drug use behaviors. They are at higher risk than adults through heterosexual exploration. AIDS education programs are the primary means to prevent HIV infection in youth. The effort to educate youth about AIDS began only after several years of the epidemic. Although education is increasing in scope and sophistication, it is not yet commensurate with the threat posed and the call by the Surgeon General in 1986 for immediate action.

Recommendations to the Secretary of Health and Human Services

GAO recommends that the Secretary require the Director of CDC to (1) take a leadership role in developing approaches to extend and reinforce HIV-related education for 11th- and 12th-grade students, (2) work with state education agencies to help smaller school districts overcome resource or community barriers preventing them from offering HIV education, (3) ensure that state and local grantees collect adequate KBB data from students to evaluate and improve school-based programs, and (4) develop guidelines for the training of teachers who instruct the HIV education courses.

Agency Comments

We discussed the contents of this report with the CDC Deputy Director (HIV), the Deputy Director of CDC's Center for Chronic Disease Prevention and Health Promotion, and the Director of the Division of Adolescent and School Health. They generally agreed with the information

presented. The officials stated that HIV education should be locally determined and consistent with parental values. These officials believe that HIV education has expanded to other school districts since the time of our data collection during the summer of 1989. CDC officials stated that data on students' knowledge, beliefs, and behaviors needed improvement but that some data, even if not generalizable, could be useful. After only 1 or 2 years of funding, the officials said, most school districts in the nation have begun rapidly to provide some form of HIV education, although much remains to be accomplished.

Appendix I

Excerpts From CDC's Guidelines for HIV Education

Planning and Implementing Effective School Health Education about AIDS

The Nation's public and private schools have the capacity and responsibility to help assure that young people understand the nature of the AIDS epidemic and the specific actions they can take to prevent HIV infection, especially during their adolescence and young adulthood. The specific scope and content of AIDS education in schools should be locally determined and should be consistent with parental and community values.

Because AIDS is a fatal disease and because educating young people about becoming infected through sexual contact can be controversial, school systems should obtain broad community participation to ensure that school health education policies and programs to prevent the spread of AIDS are locally determined and are consistent with community values.

The development of school district policies on AIDS education can be an important first step in developing an AIDS education program. In each community, representatives of the school board, parents, school administrators and faculty, school health services, local medical societies, the local health department, students, minority groups, religious organizations, and other relevant organizations can be involved in developing policies for school health education to prevent the spread of AIDS. The process of policy development can enable these representatives to resolve various perspectives and opinions, to establish a commitment for implementing and maintaining AIDS education programs, and to establish standards for AIDS education program activities and materials. Many communities already have school health councils that include representatives from the aforementioned groups. Such councils facilitate the development of a broad base of community expertise and input, and they enhance the coordination of various activities within the comprehensive school health program (6).

AIDS education programs should be developed to address the needs and the developmental levels of students and of school-age youth who do not attend school, and to address specific needs of minorities, persons for whom English is not the primary language, and persons with visual or hearing impairments or other learning disabilities. Plans for addressing students' questions or concerns about AIDS at the early elementary grades, as well as for providing effective school health education about AIDS at each grade from late elementary/middle school through junior

high/senior high school, including educational materials to be used, should be reviewed by representatives of the school board, appropriate school administrators, teachers, and parents before being implemented.

Education about AIDS may be most appropriate and effective when carried out within a more comprehensive school health education program that establishes a foundation for understanding the relationships between personal behavior and health (7-9). For example, education about AIDS may be more effective when students at appropriate ages are more knowledgeable about sexually transmitted diseases, drug abuse, and community health. It may also have greater impact when they have opportunities to develop such qualities as decision-making and communication skills, resistance to persuasion, and a sense of self-efficacy and self-esteem. However, education about AIDS should be provided as rapidly as possible, even if it is taught initially as a separate subject.

State departments of education and health should work together to help local departments of education and health throughout the state collaboratively accomplish effective school health education about AIDS. Although all schools in a state should provide effective education about AIDS, priority should be given to areas with the highest reported incidence of AIDS cases.

Preparation of Education Personnel

A team of representatives including the local school board, parent-teachers associations, school administrators, school physicians, school nurses, teachers, educational support personnel, school counselors, and other relevant school personnel should receive general training about a) the nature of the AIDS epidemic and means of controlling its spread, b) the role of the school in providing education to prevent transmission of HIV, c) methods and materials to accomplish effective programs of school health education about AIDS, and d) school policies for students and staff who may be infected. In addition, a team of school personnel responsible for teaching about AIDS should receive more specific training about AIDS education. All school personnel, especially those who teach about AIDS, periodically should receive continuing education about AIDS to assure that they have the most current information about means of controlling the epidemic, including up-to-date information about the most effective health education interventions available. State and local departments of education and health, as well as colleges of education, should assure that such in-service training is made available to all schools in the state as soon as possible and that continuing in-service and pre-service training is subsequently provided. The local school board should assure that release time is provided to enable school personnel to receive such in-service training.

Programs Taught by Qualified Teachers

In the elementary grades, students generally have one regular classroom teacher. In these grades, education about AIDS should be provided by the regular classroom teacher because that person ideally should be trained and experienced in child development, age-appropriate teaching methods, child health, and elementary health education methods and materials. In addition, the elementary teacher usually is sensitive to normal variations in child development and aptitudes within a class. In the secondary grades, students generally have a different teacher for each subject. In

these grades, the secondary school health education teacher preferably should provide education about AIDS, because a qualified health education teacher will have training and experience in adolescent development, age-appropriate teaching methods, adolescent health, and secondary school health education methods and materials (including methods and materials for teaching about such topics as human sexuality, communicable diseases, and drug abuse). In secondary schools that do not have a qualified health education teacher, faculty with similar training and good rapport with students should be trained specifically to provide effective AIDS education.

Purpose of Effective Education about AIDS

The principal purpose of education about AIDS is to prevent HIV infection. The content of AIDS education should be developed with the active involvement of parents and should address the broad range of behavior exhibited by young people. Educational programs should assure that young people acquire the knowledge and skills they will need to adopt and maintain types of behavior that virtually eliminate their risk of becoming infected.

School systems should make programs available that will enable and encourage young people who have not engaged in sexual intercourse and who have not used illicit drugs to continue to --

- Abstain from sexual intercourse until they are ready to establish a mutually monogamous relationship within the context of marriage;
- Refrain from using or injecting illicit drugs.

For young people who have engaged in sexual intercourse or who have injected illicit drugs, school programs should enable and encourage them to --

- Stop engaging in sexual intercourse until they are ready to establish a mutually monogamous relationship within the context of marriage;
- To stop using or injecting illicit drugs.

Despite all efforts, some young people may remain unwilling to adopt behavior that would virtually eliminate their risk of becoming infected. Therefore, school systems, in consultation with parents and health officials, should provide AIDS education programs that address preventive types of behavior that should be practiced by persons with an increased risk of acquiring HIV infection. These include:

- Avoiding sexual intercourse with anyone who is known to be infected, who is at risk of being infected, or whose HIV infection status is not known;
- Using a latex condom with spermicide if they engage in sexual intercourse;
- Seeking treatment if addicted to illicit drugs;
- Not sharing needles or other injection equipment;
- Seeking HIV counseling and testing if HIV infection is suspected.

State and local education and health agencies should work together to assess the prevalence of these types of risk behavior, and their determinants, over time.

Curriculum Time and Resources

Schools should allocate sufficient personnel time and resources to assure that policies and programs are developed and implemented with appropriate community involvement, curricula are well-planned and sequential, teachers are well-trained, and up-to-date teaching methods and materials about AIDS are available. In addition, it is crucial that sufficient classroom time be provided at each grade level to assure that students acquire essential knowledge appropriate for that grade level, and have time to ask questions and discuss issues raised by the information presented.

Program Assessment

The criteria recommended in the foregoing "Guidelines for Effective School Health Education To Prevent the Spread of AIDS" are summarized in the following nine assessment criteria. Local school boards and administrators can assess the extent to which their programs are consistent with these guidelines by determining the extent to which their programs meet each point shown below. Personnel in state departments of education and health also can use these criteria to monitor the extent to which schools in the state are providing effective health education about AIDS.

1. To what extent are parents, teachers, students, and appropriate community representatives involved in developing, implementing, and assessing AIDS education policies and programs?
2. To what extent is the program included as an important part of a more comprehensive school health education program?
3. To what extent is the program taught by regular classroom teachers in elementary grades and by qualified health education teachers or other similarly trained personnel in secondary grades?
4. To what extent is the program designed to help students acquire essential knowledge to prevent HIV infection at each appropriate grade?
5. To what extent does the program describe the benefits of abstinence for young people and mutually monogamous relationships within the context of marriage for adults?
6. To what extent is the program designed to help teenage students avoid specific types of behavior that increase the risk of becoming infected with HIV?
7. To what extent is adequate training about AIDS provided for school administrators, teachers, nurses, and counselors—especially those who teach about AIDS?
8. To what extent are sufficient program development time, classroom time, and educational materials provided for education about AIDS?
9. To what extent are the processes and outcomes of AIDS education being monitored and periodically assessed?

Appendix II

Estimates and Sampling Errors for Selected GAO Interview Responses

Variable	Estimated school districts (percent)	Sampling error[a] (± percentage points)
School districts requiring HIV education	66	6
School districts not requiring HIV education	27	6
School districts with grades 7-12 requiring HIV education at every grade level	5	4
School districts requiring HIV education in health courses	79	6
School districts with HIV teachers obtaining in-service training	88	5
HIV teachers receiving in-service training	83	11
School districts reporting the number of HIV teachers trained is:		
More than enough	9	5
About what is needed	64	8
Less than is needed	25	7
School districts reporting:		
They want to do more HIV in-service training	54	8
The amount of in-service already received is about right	43	8

[a]Sampling errors are computed at the 95-percent confidence level, i.e., we are 95-percent confident that the true proportion of school districts is between the ranges specified by the estimate.

Appendix III

CDC's Suggested KBB Questions for Students

AIDS is a very serious health problem in our Nation. Health officials are trying to find the best ways to teach people about AIDS and the human immunodeficiency virus (HIV), that causes AIDS. This survey has been developed so you can tell us what you know and how you feel about AIDS/HIV. The information you give will be used to develop better AIDS/HIV education programs for young people like yourself.

DO NOT write your name on this survey or the answer sheet. The answers you give will be kept private. No one will know what you write. Answer the questions based on what you really know, feel, or do.

Completing the survey is voluntary. Whether or not you answer the questions will not affect your grade in this class.

The questions in Part 1 that ask about your background will only be used to describe the types of students completing this survey. The information will not be used to find out your name. No names will ever be reported.

Place all your answer on the answer sheet. Fill in the circles completely. Make sure to answer every question. When you are finished, follow the instructions of the person giving you the survey, and place your answer sheet in the box or envelope provided for you.

You need to understand two related words used in this survey: AIDS and HIV.

- AIDS stands for acquired immunodeficiency syndrome.
- AIDS is caused by the virus, HIV.
- HIV stands for human immunodeficiency virus. HIV is the virus that causes AIDS.

THANK YOU VERY MUCH FOR YOUR HELP.

PART 1

Read each question carefully. Fill in the circle on your answer sheet that matches the letter of your answer.

1. What grade are you in?

   a. 9TH b. 10TH c. 11TH d. 12TH e. UNGRADED OR OTHER

2. What is your sex?

   a. FEMALE b. MALE

3. How old are you?

   a. 12 YEARS OLD OR YOUNGER
   b. 13-14 YEARS OLD
   c. 15-16 YEARS OLD
   d. 17-18 YEARS OLD
   e. 19 YEARS OLD OR OLDER

4. Are you Hispanic or Latino?

   a. YES b. NO

5. What is your race?

   a. BLACK
   b. WHITE
   c. AMERICAN INDIAN OR ALASKAN NATIVE
   d. ASIAN OR PACIFIC ISLANDER
   e. OTHER

PART 2

Read each question carefully. Fill in the circle on your answer sheet that matches the letter of your answer.

6. Should students your age be taught about AIDS/HIV infection in school?

   a. YES b. NO c. NOT SURE

7. Have you been taught about AIDS/HIV infection in school?

   a. YES b. NO c. NOT SURE

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8. Should a student with AIDS/HIV infection be allowed to go to your school?

   a. YES b. NO c. NOT SURE

9. Would you be willing to be in the same class with a student with AIDS/HIV infection?

   a. YES b. NO c. NOT SURE

10. Do you know where to get good information about AIDS/HIV infection?

    a. YES b. NO c. NOT SURE

11. Do you know where to get tested to see if you are infected with the AIDS virus (HIV)?

    a. YES b. NO c. NOT SURE

12. Do you know how to keep from getting the AIDS virus (HIV)?

    a. YES b. NO c. NOT SURE

13. Have you ever talked about AIDS/HIV infection with a friend?

    a. YES b. NO

14. Have you ever talked about AIDS/HIV infection with your parents or other adults in your family?

    a. YES b. NO

---

15. Can a person get AIDS/HIV infection from holding hands with someone?

    a. YES b. NO c. NOT SURE

16. Can a person get AIDS/HIV infection from sharing needles used to inject (shoot up) drugs?

    a. YES b. NO c. NOT SURE

3

33-336 0 - 90 - 9

...being bitten by mosquitos

...WOT SURE

...a person get AIDS/HIV infection from donating blood?

a. YES b. NO c. NOT SURE

19. Can a person get AIDS/HIV infection from having a blood test?

a. YES b. NO c. NOT SURE

20. Can a person get AIDS/HIV infection from using public toilets?

a. YES b. NO c. NOT SURE

21. Can a person get AIDS/HIV infection from having sexual intercourse without a condom (rubber)?

a. YES b. NO c. NOT SURE

22. Can a person get AIDS/HIV infection from being in the same class with a student who has AIDS/HIV infection?

a. YES b. NO c. NOT SURE

---

23. Can you tell if people are infected with the AIDS virus (HIV) just by looking at them?

a. YES b. NO c. NOT SURE

24. Can a person who has the AIDS virus (HIV) infect someone else during sexual intercourse?

a. YES b. NO c. NOT SURE

25. Can a pregnant woman who has the AIDS virus (HIV) ... baby with the virus?

a. YES b. NO c. NOT SURE

4

26. Is there a cure for AIDS/HIV infection?

a. YES b. NO c. NOT SURE

27. Is it true that only homosexual (gay) men can get AIDS/HIV infection?

a. YES b. NO c. NOT SURE

28. Can people reduce their chances of becoming infected with the AIDS virus (HIV) by not having any kind of sexual intercourse (being abstinent)?

a. YES b. NO c. NOT SURE

29. Can people reduce their chances of becoming infected with the AIDS virus (HIV) by using condoms (rubbers) during sexual intercourse?

a. YES b. NO c. NOT SURE

30. Can people reduce their chances of becoming infected with the AIDS virus (HIV) by not having any kind of sexual intercourse with a person who has injected (shot up) drugs?

a. YES b. NO c. NOT SURE

31. Can people reduce their chances of becoming infected with the AIDS virus (HIV) by taking birth control pills?

a. YES b. NO c. NOT SURE

PART 3

Read each question carefully. Fill in the circle on your answer sheet that matches the letter of you answer.

32. Have you ever injected (shot up) cocaine, heroin, or other illegal drugs into your body?

a. YES b. NO

5

[illegible] have you injected (shoot up) cocaine, heroin, or [illegible] into your body?

[illegible]

34. Have you EVER shared needles used to inject (shoot up) any drugs?

a. YES b. NO

35. In the last year, have you shared needles used to inject (shoot up) any drugs?

a. YES b. NO

36. With how many people have you had any kind of sexual intercourse in your life?

a. 0 b. 1 c. 2 d. 3 e. 4 OR MORE

37. With how many people have you had any kind of sexual intercourse in the last year?

a. 0 b. 1 c. 2 d. 3 e. 4 OR MORE

38. How old were you the first time you had any kind of sexual intercourse?

a. I HAVE NEVER HAD ANY KIND OF SEXUAL INTERCOURSE
b. 12 YEARS OLD OR YOUNGER
c. 13-14 YEARS OLD
d. 15-16 YEARS OLD
e. 17-18 YEARS OLD

[illegible] when you have any kind of sexual intercourse, how often is a condom [illegible] used?

[illegible] SEXUAL INTERCOURSE

Appendix IV

Topics Covered During In-Service Training by 13 CDC-Funded Districts

Training topics	Length of coverage (percentage of districts)[a] More than 15 min.	15 min. or less	Not at all	Don't know
How HIV is transmitted	100	0	0	0
Behaviors that put a person at risk for getting HIV	100	0	0	0
Unprotected heterosexual intercourse as a risky behavior	85	15	0	0
Unprotected homosexual intercourse as a risky behavior	85	15	0	0
Multiple sex partners as a risky behavior	69	31	0	0
IV drug use as a risky behavior	85	15	0	0
Importance of using condoms to prevent the spread of HIV	92	8	0	0
How blood and other bodily fluids should be handled for HIV infection control	85	8	8	0
How to handle embarrassing questions from students	85	15	0	0
How to raise students' self-esteem	85	15	0	0
How to teach students to resist peer pressure	92	8	0	0
How to communicate sensitive subjects to students	92	8	0	0
Legal and other policies related to AIDS that school districts should follow	69	31	0	0
Resources available in the community to deal with HIV issues	85	15	0	0

[a]Percentages may total to more than 100 due to rounding.

Appendix V

Topics Covered During In-Service Training by School Districts Nationwide

Training topics	Length of coverage (percentage of districts)[a,b] More than 15 min.	15 min. or less	Not at all	Don't know
How HIV is transmitted	85	8	0	7
Behaviors that put a person at risk for getting HIV	76	16	0	7
Unprotected heterosexual intercourse as a risky behavior	45	52	2	1
Unprotected homosexual intercourse as a risky behavior	38	59	2	2
Multiple sex partners as a risky behavior	39	59	1	2
IV drug use as a risky behavior	61	38	1	0
Importance of using condoms to prevent the spread of HIV	46	52	2	0
How blood and other bodily fluids should be handled for HIV infection control	55	35	1	9
How to handle embarrassing questions from students	55	30	6	9
How to raise students' self-esteem	46	33	10	11
How to teach students to resist peer pressure	80	27	6	7
How to communicate sensitive subjects to students	53	32	6	10
Legal and other policies related to AIDS that school districts should follow	40	43	7	10
Resources available in the community to deal with HIV issues	42	46	3	10

[a]Percentages may not total 100 due to rounding.

[b]Sampling errors for these percentages do not exceed 8 percentage points.

Appendix VI

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United States General Accounting Office

GAO

Report to the Chairman, Committee on Governmental Affairs, U.S. Senate

May 1990

AIDS EDUCATION

Programs for Out-of-School Youth Slowly Evolving

GAO/HRD-90-111

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-239254

May 1, 1990

The Honorable John Glenn
Chairman, Committee on
Governmental Affairs
United States Senate

Dear Mr. Chairman:

This report responds to your request concerning education programs to prevent the spread of the human immunodeficiency virus (HIV), which causes acquired immunodeficiency syndrome (AIDS). It summarizes the Centers for Disease Control (CDC) efforts to educate out-of-school youth. We are issuing a companion report on HIV education in the public school system.[1]

Results in Brief

CDC has accomplished relatively little in providing HIV education to out-of-school youth. This is because: (1) CDC's Center for Chronic Disease Prevention and Health Promotion (CCDPHP), which has lead responsibility for youth, initially targeted the larger, in-school population; (2) the state and local education agencies funded to serve all youth lacked experience with those out of school and the organizations that serve them; and (3) few guidelines or specifically targeted educational materials were available. To overcome these barriers, CCDPHP plans to fund local health departments or community organizations to act as focal points for providing services to out-of-school youth, including HIV education. However, this approach is already being carried out by another center within CDC, the Center for Prevention Services (CPS). Therefore, we believe that CDC should reassess its current strategy toward reaching high-risk, out-of-school youth, specifically considering whether the out-of-school youth component of CCDPHP should be merged with CDC's existing prevention programs.

Background

Out-of-school youth, including runaways and homeless, migrants, and those incarcerated, are at greater peril of AIDS than other youth because they are more likely to engage in high-risk sexual and drug activities.[2]

[1] AIDS Education: Public School Programs Require More Student Information and Teacher Training (GAO/HRD-90-103, May 1, 1990).

[2] See the Office of Technology Assessment report, How Effective Is AIDS Education?, June 1988; Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic, June 1988; and Report of the Surgeon General's Workshop on Children With HIV Infection and Their Families, 1987.

Data suggest that the rate of HIV infection among out-of-school youth may be higher and increasing faster than the rate among the general adolescent population. This group is also more troubled, has less adult support, and is much less accessible and trusting than in-school youth who live in their own homes.[2] Many stay in contact with other youth or resort to prostitution, thereby serving as a possible conduit of HIV infection from high- to low-risk groups.

People in their 20s accounted for about 20 percent of all reported AIDS cases through 1989. The number of AIDS cases among this group in 1989 increased by 41 percent, which was similar to the overall increase in AIDS cases. HIV infection occurs years before AIDS is manifest; during this time, the virus is infectious to other people. Because the average incubation period between HIV infection and the time people actually exhibit AIDS symptoms is about 10 years, adults who have AIDS in their 20s most likely contracted HIV as adolescents.

Experts conclude that it is more difficult for those youth who may be troubled and who lack adult guidance to refrain from high-risk behaviors than other adolescents. Additionally, those out of school have more serious psychological problems, such as depression and anxiety, and behavioral problems, such as suicidal tendencies and problems with conduct, that may influence their risk-taking behavior.

The National Network for Runaway and Youth Services estimates that homeless and runaway youth number between 1.3 and 2.0 million yearly, and that between 100,000 and 300,000 are long-term runaways or "street kids," who fend for themselves most often by drug dealing and prostitution.

HIV education programs should be tailored to a youth's age and level of functioning and consist of information on what AIDS and HIV are, how the virus is spread, and what people can do to prevent infection. Educating out-of-school youth is particularly demanding because they are difficult to reach, practice risky behaviors, and face a myriad of other problems that make their education arduous. An effective AIDS education program for these youth should include strategies to provide them with information and materials on AIDS transmission and prevention in a language they can understand, develop practical and realistic skills to change

[2]For further information, see Homelessness: Homeless and Runaway Youth Receiving Services at Federally Funded Shelters (GAO/HRD-90-45, Dec. 19, 1989).

high-risk behaviors, and supply their immediate needs. We refer to education related to all phases of the disease as HIV education in the remainder of this report.

Objective, Scope, and Methodology

Our main objective was to provide information on the status of CDC's Center for Chronic Disease Prevention and Health Promotion efforts to educate out-of-school youth about AIDS. Specifically, we sought to determine the initiatives and funding targeted at providing HIV education to out-of-school youth. We reviewed CDC's Division of Adolescent and School Health HIV Education Program endeavors within CCDPHP. We examined CDC records and interviewed CDC officials. We interviewed administrators from the national organizations (such as the National Network for Runaway and Youth Services) funded to reach out-of-school or minority youth and state and local education agency recipients. We selected and interviewed officials from community-based organizations (such as runaway shelters and crisis centers) primarily serving out-of-school youth. Appendix I provides a complete listing of the organizations and agencies we contacted.

We also examined HIV education programs, which may serve out-of-school youth funded by CDC's Center for Preventive Services, other federal agencies, and selected community-based organizations through interviews with appropriate officials.

We conducted our review between May and December 1989 in accordance with generally accepted government auditing standards.

CCDPHP Programs Targeting High-Risk, Out-of-School Youth Slow to Develop

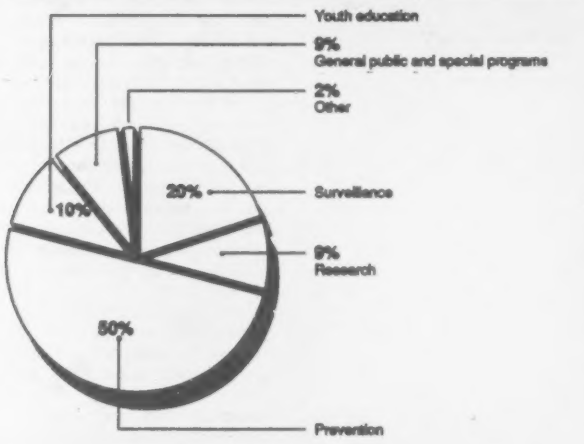
CCDPHP is CDC's lead center responsible for HIV education for school-aged youth. The Division of Adolescent and School Health in CDC's CCDPHP initiated a nationwide HIV education program for youth in fiscal year 1987. For 3 project years, CCDPHP has provided assistance to state and local education agencies and national organizations to help schools and organizations serving youth implement HIV education programs.

CCDPHP Focused Prevention Resources on the In-School Population

In fiscal year 1987, CDC allocated $136 million of its budget for all AIDS programs. This increased to about $438 million in fiscal year 1990. Most of these funds were used for prevention activities, such as counseling and testing, health education and risk reduction, and minority initiatives, which are administered by another component of CDC, CPS (see

pp. 7-8). About 10 percent of this overall funding was targeted specifically for youth education activities in CCDPHP (see fig. 1).

Figure 1: Fiscal Year 1990 CCDPHP Funding for HIV/AIDS Programs

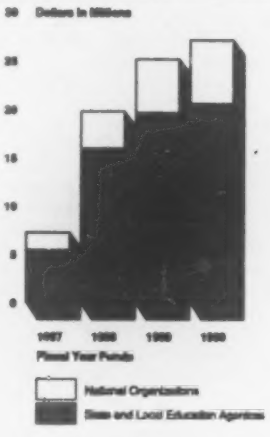


CDC initially targeted the funds for youth in the in-school population. CDC administrators said they did so because young people in school are in an organized system and it was easier and more efficient to reach them. Also, they constituted the majority of youth, and HIV education in the school system could influence behavior before they dropped out of school.

CCDPHP distributed nearly 80 percent of HIV education funds between fiscal years 1987 and 1989 to state and local education agencies to support HIV education programs for all youth. In 1989, $19.6 million was awarded to 71 state and local programs for HIV education for youth. The average amount per program was less than $276,000 to cover both in-school and out-of-school HIV education. CCDPHP expects to award $20.55 million to education agencies in fiscal year 1990.

CCDPHP also provided $3.8 million in 1988 and $5.5 million in 1989 to national organizations, such as the National Network for Runaway and Youth Services (see fig. 2). The average amount provided was about $285,000 in 1989. In 1989, CDC funded 19 national organizations, of which 6 targeted out-of-school or minority youth. A brief description of the CCDPHP-funded projects in each of these national organizations is in appendix II. CCDPHP expects to award about $6.5 million to national organizations in fiscal year 1990. CCDPHP chose to use cooperative agreements as the funding mechanism for state, local, and national groups. This mechanism allowed recipients considerable flexibility in structuring their programs.[4]

Figure 2: Distribution of Funds in Fiscal Years 1987-90, CCDPHP Youth HIV Education Program



Note: Fiscal year 1990 funding allocations are estimated.

Through the cooperative agreement process, CCDPHP requested that education departments develop HIV education programs for in-school youth.

[4]A cooperative agreement is a financial assistance mechanism used in lieu of a grant when substantial federal programmatic involvement with the recipient during performance is anticipated.

These programs were to include (1) developing HIV curricula and training materials, (2) training teachers, (3) attending workshops or conferences, and (4) completing surveys of students' HIV knowledge, beliefs, and behaviors. CDC also expected these departments to develop education programs for out-of-school youth and to collaborate with organizations that work with these youth.

While in-school education programs have been launched in most school districts, in our companion report we identified deficiencies in the extensiveness of HIV education programs and the level of training of teachers that are due in part to insufficient funding.

CCDPHP-Funded HIV Education for Out-of-School Youth Is Limited

Generally, CCDPHP-funded HIV education for out-of-school youth has been limited. CCDPHP relies on state and local education agencies to promote efforts to reach this group. CCDPHP also provides 5.6 percent of the total youth HIV education funds to six national organizations to target their efforts to out-of-school youth in fiscal year 1989.

Under the cooperative agreements, state and local education agencies designed their own HIV education programs. CCDPHP provided no specific guidance on how to approach out-of-school youth; the agreement announcement stated only a broad objective. Nor did CCDPHP specify what portion of any particular cooperative agreement was to be spent on out-of-school youth. Consequently, state and local education agencies (the majority of recipients) focused most efforts in their area of expertise, in-school youth. CCDPHP estimated that about 4 percent of state and about 7 percent of local education agency funds have been spent on out-of-school youth in fiscal year 1989.

Very few of the education agencies targeted out-of-school youth for any HIV education services. Such services included direct outreach or instruction and design of appropriate HIV education materials and curricula. After 2 years of funding about one-third of the originally funded state education agencies had done little more than some preliminary planning and identifying organizations working with out-of-school youth. Even those local education agencies actively developing programs for out-of-school youth primarily targeted alternative education programs, such as programs for teenaged parents or problem youth within the school system, rather than homeless or runaway youth. None had conducted surveys to obtain baseline data on youth's HIV knowledge, beliefs, and behaviors.

Reported barriers to education for this high-risk group included the following: (1) state and local education agencies lacked experience with out-of-school youth and the organizations that serve them, (2) few guidelines or educational materials targeted to out-of-school youth were available, (3) communities have resisted HIV education, and (4) out-of-school youth are difficult to reach.

CCDPHP Has Strengthened Cooperative Agreement Requirements to Target Out-of-School Youth

It was not until the third project year (fiscal year 1989), that CCDPHP requested state and local education agency recipients to specify objectives and program activities for out-of-school youth. These required activities include: (1) developing data on the number of agencies assisted by the recipient that provide HIV education to out-of-school youth, (2) assisting schools and local education agencies in reaching groups that serve out-of-school youth, and (3) promoting effective HIV education programs in schools and agencies serving out-of-school youth.

CCDPHP Plans to Overcome Barriers to HIV Education Efforts by Relying on Health Departments

Because education agencies had difficulties serving out-of-school youth, CCDPHP plans to target these youth through adolescent health programs in local health departments or some other locally designated agency. Later this year, CCDPHP hopes to award about $1.5 million among such lead agencies in six cities with a high incidence of AIDS. The designated agencies will coordinate community HIV education efforts in those cities. As part of this initiative, each community will conduct a needs assessment to identify service and policy gaps and devise a comprehensive approach to provide the full range of services, including HIV education, to out-of-school youth.

CDC's Center for Prevention Services Funds HIV Prevention Activities Targeting Out-of-School Youth

While CCDPHP has only recently begun to focus its program on out-of-school youth, the Center for Prevention Services has been funding prevention programs through cooperative agreements with health departments and community-based organizations to populations at risk, including out-of-school youth. CPS has programs in place that reach out-of-school youth and include: (1) state and local health department prevention programs to support Health Education and Risk Reduction activities and special Minority Initiatives, (2) AIDS Community Demonstration Projects to conduct research on community HIV education strategies, and (3) directly funded community-based organizations to develop HIV prevention programs for minority and high-risk groups.

Under the first program, Health Education and Risk Reduction, activities include group counseling of HIV-infected individuals and street outreach programs for intravenous-drug users, prostitutes, and runaway youth. The goal is to enlist the support of those at risk, HIV-infected individuals, minorities, and school educators. Minority Initiatives include street outreach efforts targeting street youth or intravenous-drug users and referral of high-risk individuals to medical and testing sites by community-based minority organizations.

Under the AIDS Community Demonstration Project, CPS has funded AIDS projects in seven locations across the country to develop, implement, and evaluate approaches to prevent HIV transmission. The projects focus on hard-to-reach populations, such as intravenous-drug users not in treatment, sex partners of intravenous-drug users, prostitutes, and street youth.

CPS directly funded 64 community-based organizations in July 1989 to develop HIV programs for minorities and high-risk groups in the metropolitan statistical areas most heavily affected. One objective of these awards is to establish collaboration among community organizations, HIV education and prevention service agencies, and public organizations, such as local and state health departments. The programs will target youth, men who have sex with men, intravenous-drug users, female partners of persons at risk, prostitutes, and the homeless. Activities include street outreach, peer education, and drug education.

While we have not evaluated the effectiveness of CPS programs, CPS does target out-of-school youth. The new initiative in CCDPHP for out-of-school youth appears to duplicate the already functioning, larger CPS programs.

Other Federal Efforts to Educate Out-of-School Youth

Other federal programs provide or support HIV education and prevention projects for out-of-school youth. The Job Corps requires AIDS education as part of its curriculum. The Health Resources and Services Administration funded demonstration projects to support and coordinate a wide range of AIDS treatment and support services, such as outreach, education, and prevention services, in cities with the highest incidence of reported AIDS cases.

Three federal agencies—the National Institute of Mental Health, the National Institute on Drug Abuse, and the Office of Juvenile Justice and Prevention Delinquency—funded studies to develop and assess the effectiveness of intervention programs in promoting behavior change in

runaway and homeless youth. Appendix III provides a brief description of each project.

Groups Not Funded by CCDPHP Provided Most HIV Education

In addition to CCDPHP, other organizations funded out-of-school HIV education efforts. Health departments and other groups have relied on community-based organizations as the most frequent direct providers of HIV education to out-of-school youth. Most were runaway shelters, runaway referral centers, or drop-in centers. About three-fourths of these organizations received some funds specifically for educating out-of-school youth directly from federal agencies other than CDC (see app. III), public health departments, and private foundations, such as the Robert Wood Johnson Foundation. Activities included street outreach; distribution of condoms and HIV education pamphlets; video presentations; group sessions; peer education; and addressing basic needs, such as food, clothing, and shelter.

Conclusions

The youth HIV education program has multiple objectives. However, funding for cooperative agreements has been relatively low. The Center for Chronic Disease Prevention and Health Promotion has historically dealt with health education for youth. CCDPHP originally worked primarily with education agencies and focused on in-school youth. It provided little guidance to cooperative agreement recipients to focus on out-of-school youth. As a result, after 3 project years, most attention has been focused on in-school youth and little attention on out-of-school youth. To remedy this problem, CCDPHP plans to sponsor adolescent health programs in local health departments or community-based organizations.

CCDPHP has started developing ties with the health departments and community-based organizations that serve out-of-school youth. However, existing HIV programs in the Center for Prevention Services have been working with these types of organizations and are reaching out-of-school youth. Our work did not focus on how well CPS has served these youth, but CPS has systems in place and previous experience with this group.[5]

[5]See AIDS Education: Issues Affecting Counseling and Testing Programs (GAO/HRD-89-39, Feb. 3, 1989) and AIDS Education: Staffing and Funding Problems Impair Progress (GAO/HRD-89-124, July 28, 1989). We have reported management issues in CPS concerning staffing levels, funding cycles, and collecting baseline data.

Recommendation to the Director of the Centers for Disease Control

In view of the potential duplication in CDC-funded activities, the Director of the Centers for Disease Control should consider merging the activities of the Center for Chronic Disease Prevention and Health Promotion aimed at out-of-school youth education into the Center for Prevention Services.

Agency Comments

At the request of the committee, we did not obtain formal comments on this report. We discussed the contents of this report with agency officials and incorporated their technical and factual comments from correspondence received as appropriate.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies to the Secretary of Health and Human Services, the Director of CDC, and other interested parties and will provide copies to others on request.

Please contact me on (202) 275-6195 if you or your staff have any questions concerning this report. Other major contributors to this report are listed in appendix VI.

Sincerely yours,

Mark V. Nadel

Mark V. Nadel
Associate Director, National and
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Abbreviations

AIDS	acquired immunodeficiency syndrome
CCDPHP	Center for Chronic Disease Prevention and Health Promotion
CDC	Centers for Disease Control
CPS	Center for Prevention Services
HIV	human immunodeficiency virus

Appendix I

Agencies Contacted During Our Review

Federal Agencies	
Department of Health and Human Services	Centers for Disease Control. National Institute of Mental Health. National Institute of Drug Abuse. Health Resources and Services Administration.
Department of Justice	Office of Juvenile Justice and Delinquency Prevention.
Department of Labor	Office of the Job Corps.
National Organizations	National Network of Runaway and Youth Services. National Organization of Black County Officials. National Coalition of Advocates for Students. National Coalition of Hispanic Health and Human Services Organizations. National Commission on Correctional Health Care. Center for Population Options.
State Education Agencies	California State Department of Education. Colorado Department of Education. Connecticut State Department of Education. Florida Department of Education. Illinois State Board of Education. New York State Education Department. Texas Education Agency.
Local Education Agencies	School Board of Dade County (Miami). Dallas Independent School District. Denver Public Schools. Newark Board of Education. New York City Board of Education. San Francisco Unified School District.

Community-Based Organizations

California	Diamond Youth Shelter, San Francisco. Huckleberry House, San Francisco. Larkin Street Youth Center, San Francisco. Youth and Family Assistance, Redwood City. Children of the Night, Hollywood. Options House, Hollywood. Gay and Lesbian Adolescent Social Services, Hollywood. Avance Human Services, Los Angeles.
New York City	Adolescent Development Program. Covenant House. Emergency Shelter. Victims Services Agency. Adolescent AIDS Program. Project Streetbeat.
Other States	The Bridge, Inc., Boston, Massachusetts. The Miami Bridge, Miami, Florida. The Middle Earth, Austin, Texas. Outreach, Inc., Atlanta, Georgia. Seattle Youth and Community Services, Seattle, Washington. Southeast Network of Youth and Family Services, Durham, North Carolina. Youth Emergency Services and Shelter, Des Moines, Iowa.

Appendix II

CCDPHP-Funded National Organizations Targeting Out-of-School Youth

National Network of Runaway and Youth Services	The National Network of Runaway and Youth Services' Safe Choices Project, funded in fiscal years 1987, 1988, and 1989, is a comprehensive HIV-prevention education effort for reaching runaway and homeless youth. The cornerstone of the project is an HIV education guide to help runaway and homeless youth service organizations develop HIV education policies and implement programs for high-risk youth.
National Organization of Black County Officials	The National Organization of Black County Officials, funded in fiscal years 1987, 1988, and 1989, is developing a model HIV education and prevention program targeting black and minority youth. The model program involves outreach, training, and curriculum development.
National Coalition of Hispanic Health and Human Services Organizations	The National Coalition of Hispanic Health and Human Services Organizations, funded in fiscal years 1987, 1988, and 1989, is designed to increase the number of Hispanic youth service agencies offering HIV education. The project supports local training activities in Hispanic youth service agencies.
National Coalition of Advocates for Students	Staff of the National Coalition of Advocates for Students, funded in fiscal years 1987, 1988, and 1989, work with community-based organizations, health agencies, and migrant and immigrant organizations to help provide HIV education to migrant and immigrant youth. The project raises HIV education awareness in, and provides HIV education materials to, these organizations.
Center for Population Options	Although funded in fiscal year 1987, 1988, and 1989, the Center for Population Options did not implement an out-of-school youth component until the second project year. The Center provides training workshops and technical assistance to three affiliates of Big Brothers Big Sisters, YMCA, and the Salvation Army to assist them in developing their own HIV education programs for high-risk youth.
National Commission on Correctional Health Care	The National Commission on Correctional Health Care received funding in fiscal years 1988 and 1989 to help juvenile confinement facilities provide HIV education.

Appendix III

Non-CDC-Funded Federal Programs Addressing HIV Education for Out-of-School Youth

Department of Health and Human Services

National Institute of Mental Health and National Institute on Drug Abuse

The National Institute of Mental Health and the National Institute on Drug Abuse funded the HIV Center for Clinical and Behavioral Studies at Columbia University in September 1987 for a 5-year study to evaluate the effectiveness of HIV education programs for out-of-school youth. Funding for this study through January 31, 1991, totals $941,805. Specifically, the Center is designing and evaluating an intervention program to decrease high-risk behaviors among gay and runaway youth.

The program consists of four efforts aimed at mediating high-risk behaviors to: (1) build on existing programs to increase youth's general knowledge of AIDS; (2) personalize this knowledge; (3) allow youth to practice interpersonal assertiveness; and (4) develop a support network to provide health care, including access to condoms.

Health Resources and Services Administration

The Health Resources and Services Administration awards service demonstration projects to support and coordinate a wide range of treatment and support services in cities with the highest incidence of reported AIDS cases. Support services include outreach, education, and prevention services for ethnic and minority populations engaging in high-risk behaviors and for intravenous-drug users. By the end of fiscal year 1989, the administration had awarded approximately $60 million to support 25 service demonstration projects in 15 states; Washington, D.C.; and Puerto Rico and requested $14.8 million to continue these projects in fiscal year 1990.

National Institute on Drug Abuse

Since 1987, the National Institute on Drug Abuse has conducted a National AIDS Demonstration Research Project, which assesses the effectiveness of various education and intervention techniques in promoting behavior changes to reduce the risk of HIV. Some of the project's 29 comprehensive community outreach demonstration research cooperative agreements, as well as 12 AIDS-targeted outreach research contracts, focus on runaway and delinquent youth. In fiscal year 1990, the Institute awarded a total of $36 million for this project.

Department of Justice

Office of Juvenile Justice and Delinquency Prevention

The Office of Juvenile Justice and Delinquency Prevention funded an initiative on prevention and intervention for illegal drug use and AIDS among high-risk youth. The Office awarded a $400,000 cooperative agreement to the Education Development Center in 1988 to develop and test ways to assist public and private agencies in providing comprehensive prevention and intervention services to runaway and homeless youth. Comprehensive services to respond to the problems of AIDS, illegal drug use, and sexual exploitation among these youth include outreach, crisis intervention, intermediate, long-term, and after-care programs. The Center plans to subcontract the National Network for Runaway and Youth Services to help carry out this research and development.

Department of Labor

Job Corps

The Office of the Job Corps provides basic educational and vocational training for youth aged 16 to 21 who are severely educationally or economically disadvantaged. The training is primarily provided in a residential setting in which youth are provided with housing, food, clothing, and medical and dental care. About 60,000 youth receive training in the program each year, with an average length of stay of about 8 months. All Job Corps staff and students must receive HIV education.

Appendix IV

Major Contributors to This Report

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